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Key to Abbreviations in This Index

Or.—Original Article (Scientific and General).
C.R.—Case Report (Clinical Notes).
Ed.—Editorial.
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In addition to the elected district and at-large Councilors, the Council has as ex-offico members the following general officers, President; President-Elect; Past-President; Speaker; and the Association Secretary.
Council Officers: Philip K. Gilman, Chairman; George H. Kress, Secretary.

District Councilors

First District—Imperial, Orange, Riverside, San Bernardino and San Diego Counties, Herbert A. Johnston (1947), 117 N. Claudina Street, Anaheim.

Second District—Los Angeles County, Donald Cass (1945), 5300 Hollywood Boulevard, Los Angeles, 27.

Third District—Inyo, Kern, Mono, San Luis Obispo, Santa Barbara and Ventura Counties, Harry E. Henderson (1946), 1421 State Street, Santa Barbara.

Fourth District—Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, Axcel E. Anderson (1947), Medical Group Building, 1759 Fulton Street, Fresno.

Fifth District—Monterey, San Benito, San Mateo, Santa Clara and Santa Cruz Counties, R. Stanley Kneeshaw (1945), 404 Medico-Dental Building, 241 East Santa Clara Street, San Jose.

Sixth District—San Francisco County, John W. Cline (1946), 1020 Medico-Dental Building, 490 Post Street, San Francisco.

Seventh District—Alameda and Contra Costa Counties, Lloyd E. Kindall (1947), 400 Twenty-ninth Street, Oakland.

Eighth District—Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba Counties, Frank A. MacDonald (1945), 822 Medico-Dental Building, 1127 Eleventh Street, Sacramento.

Ninth District—Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W. Green (1946), Box 539, Vallejo.

Councilors-at-Large

Sam J. McClendon (1945), 2654 Fourth Avenue, San Diego, 3.

Edwin L. Bruck (1945), 384 Post Street, San Francisco, 8.

Sidney J. Shipman (1947), 490 Post Street, San Francisco 2.

E. Earl Moody (1947), 829 South Alvarado Street, Los Angeles.

Dewey R. Powell (1946), Room 501, 242 North Sutter Street, Stockton.

Edward B. Dewey (1946), Professional Building, 65 North Madison Avenue, Pasadena.

Standing Committees

Executive Committee

The President, the President-Elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Past President, the Secretary-Treasurer (ex officio), and the Editor (ex officio). John W. Cline, Chairman; George H. Kress, Secretary.

Auditing Committee*

John W. Cline (Chairman)	San Francisco	1944
Edwin L. Bruck	San Francisco	1944
Lloyd E. Kindall	Oakland	1944

Committee on Associated Societies and Technical Groups

Clarence E. Rees	San Diego	1945
John V. Barrow (Chairman)	Los Angeles	1946
Anthony B. Diepenhrock	San Francisco	1947

Committee on Health and Public Instruction

C. M. Burchfiel	San Jose	1945
J. C. Geiger (Chairman)	San Francisco	1946
E. Earl Moody	Los Angeles	1947

Committee on History and Obituaries

Robert A. Peers	Colfax	1945
Hyman Miller	Los Angeles	1946
Morton R. Gibbons, Sr. (Chairman)	San Francisco	1947
George H. Kress	ex officio	

Committee on Hospitals, Dispensaries and Clinics

J. Norman O'Neill	Los Angeles	1945
Benjamin B. Black	Oakland	1946
Roy E. Thomas (Chairman)	Los Angeles	1947

Committee on Industrial Practice

Donald Cass (Chairman)	Los Angeles	1945
Carl L. Hoag	San Francisco	1946
N. P. Dunne	Oakland	1947

Committee on Medical Defense

R. Stanley Kneeshaw	San Jose	1945
Lewis T. Bullock	Los Angeles	1946
Nelson J. Howard (Chairman)	San Francisco	1947

Committee on Medical Economics

C. A. Broaddus	Stockton	1945
Edward C. Pallette	Los Angeles	1946
Glenn F. Cushman (Chairman)	San Francisco	1947

Committee on Medical Education and Medical Institutions

L. R. Chandler	San Francisco	1945
William J. Kerr	San Francisco	1946
B. O. Raulston (Chairman)	Los Angeles	1947

Committee on Organization and Membership

J. F. Doughty (Chairman)	Tracy	1945
L. H. Redelings	San Diego	1946
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Committee on Postgraduate Activities

Frank A. MacDonald	Sacramento	1945
F. E. Clough (Chairman)	San Bernardino	1946
H. F. Friedell	Santa Barbara	1947
George H. Kress	ex officio	

Committee on Publications

Francis E. Toomey	San Diego	1945
George W. Walker (Chairman)	Fresno	1946
F. Burton Jones	Vallejo	1947

Secretary and Editor ex officio

Committee on Public Policy and Legislation

Lloyd E. Kindall	Oakland	1945
Edmund T. Remmen	Glendale	1946
Dwight H. Murray (Chairman)	Napa	1947
Association President	ex officio	
Association President-Elect	ex officio	

Advisory Committee

Junius B. Harris (Chairman)	Sacramento
H. R. Madeley (Vice-Chairman)	Vallejo

Committee on Scientific Work

George H. Kress (Chairman)	ex officio	
Howard F. West	Los Angeles	1945
Fletcher B. Taylor	Oakland	1946
J. Homer Woolsey	Woodland	1947
Salvatore P. Lucia	(ex officio, Secretary, Section on Medicine)	
Leon Goldman	(ex officio, Secretary, Section on Surgery)	

Committee on Public Relations

The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Donald Cass, the secretary is Mr. John Hunton.

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Roy E. Thomas	Chair, Com. on Hospitals, Dispensaries, Clinics
Donald Cass	Chair, Com. on Industrial Practice
Nelson J. Howard	Chair., Com. on Medical Defense
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Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

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Henry J. Ullmann	Santa Barbara	1945
Clarence J. Berne	Los Angeles	1945
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Lyell C. Kinney (Vice-Chairman)	San Diego	1946
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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, Donald D. Lum, 2225 Central Avenue, Alameda.
Secretary, Gertrude Moore, 353 30th Street, Oakland, 9.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Daniel H. Moulton, P. O. Box 520, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, William Powell, Room 125, Hall of Records, Martinez.
Secretary, George C. Kelso, 416 East Fourth Street, Pittsburg.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, 2607 Fresno Street, Fresno, 1.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Carl T. Wallace, Sixth and I Streets, Eureka.
Secretary, Joseph S. Woolford, 539 G Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Marian Hubbell, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, George D. Shultz, Lone Pine.
Secretary, Lloyd S. Bambauer, Bishop.
Meeting, *Fourth Wednesday, except December, January, February.*

Kern County Medical Society
President, Henry A. Rivin, 820 Tenth Avenue, Delano.
Acting Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:30 p. m., Motel Inn, Bakersfield, except June, July and August.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, Fred J. Davis, Jr., 920 Pine Street, Susanville.
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
President, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles, 5.
Secretary, E. T. Remmen, 429 North Orange, Glendale.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Ralph Weseman, Novato.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, Louise E. Petty, Talmage.
Secretary, Dale E. Barber, Fort Bragg.

Merced County Medical Society
President, E. R. Fountain, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Charles A. Galligan, P. O. Box 431, Monterey.
Secretary, Arnold Manor, 578 Polk Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Charles H. Bulson, 1203 Seminary Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, Charles E. Irvin, 105 West Sycamore Street, Anaheim.
Secretary, Russell I. Johnson, 181 Seventeenth Street, Westminster.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Denver D. Roos, Corona.
Secretary, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Wayne E. Pollock, 1127 Eleventh Street, Sacramento 14.
Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento 14.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, J. J. Haruff, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Kenneth L. Dole, Medical Arts Building, Redlands.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, R. H. Sundberg, 2001 Fourth Avenue, San Diego, 1.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 6.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Stanley H. Mentzer, 450 Sutter Street, San Francisco, 8.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco, 2.
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

San Joaquin County Medical Society
President, Warren T. McNeil, Medico-Dental Building, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton 3.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
George K. Dunklee, 1130 Garden Street, San Luis Obispo.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Erma B. Macomber, 1515 Broadway, Burlingame.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, H. L. Schurmeier, 6 E. Arrellaga Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, George A. Gray, Sainte Claire Building, San Jose, 23.
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

Santa Cruz County Medical Society
President, Anton J. Sambuck, Union Street and Maple Avenue, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, Roy W. Thomas, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, H. Randall Madeley, P. O. Box 539, Vallejo.
Secretary, Charles H. Widenmann, 405 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, William N. Makaroff, Guerneville.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Ralph E. Maxwell, 911 Thirteenth Street, Modesto.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, James C. Malcolm, 1501 West Main, Visalia.

Ventura County Medical Society
President, A. H. Stoll, 329 North Fifth Street, Oxnard.
Secretary, Gerald K. Ridge, 704 East Santa Clara Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, J. Homer Woolsey, Woodland Clinic, Woodland.
Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Joseph J. Salopek, 423 Fourth Street, Marysville.
Secretary, Harry Clemens, 725 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(For roster of C. M. A. committees and other organizations, see last month's issue)

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(Continued from Page 3)

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In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 364 Fourteenth Street, Oakland, 12; 153 Kearny Street, San Francisco; 675 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles 5. Phone FItzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, also maintains a medical literature packet service.

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* Commenting editorially on the work of Mills and Cottingham (J. Immunol. 47:503 [Dec.] 1943), THE JOURNAL states: "They found that after five and one-half weeks maintenance at 68 F. rats showed a maximum phagocytic activity on diets containing 18 per cent of protein. There was a definite decrease in phagocytic activity with an increase or decrease from this level. In rats maintained at 90+F. the phagocytic optimum diet was 36 per cent of protein. Thus adequate protein intake would seem to be fully as important as adequate vitamin intake to maintain optimal phagocytic activity (resistance to microbic infections). The immunologic optimum protein intake is higher in the tropics than in temperate climates. . . . This demonstration of important variations in phagocytic functions is a pioneer contribution to basic immunologic theory and may have wide clinical implications." (J.A.M.A. 124:1203 [April 22] 1944.)

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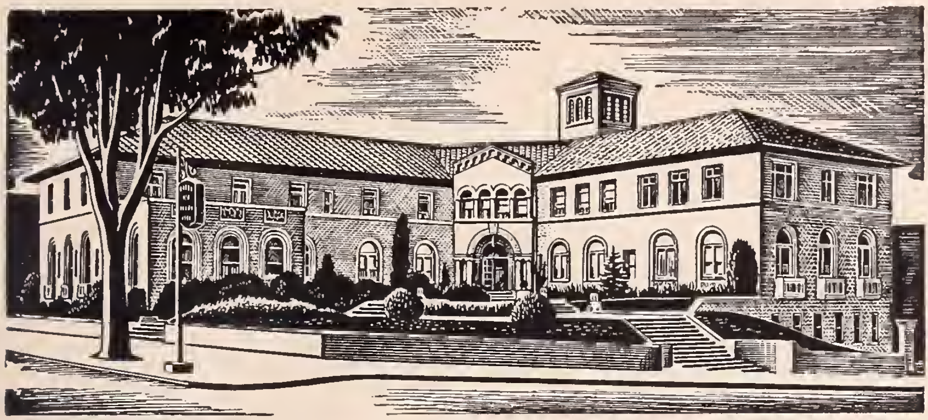

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BOOK REVIEWS

BOOKS RECEIVED

Technique in Trauma. Planned Timing in the Treatment of Wounds Including Burns. From The Montreal General Hospital and McGill University. By Fraser B. Gurd, M.D., C.M. and F. Douglas Ackman, M.D., C.M. In Collaboration With John W. Gerrie, M.D., C.M.; Joseph E. Pritchard, M.D.; Edward S. Mills, M.D., C.M., and Frederick Smith, M.D. Preface by John S. Lockwood, M.D., University of Pennsylvania, with Commentary by Ralph R. Fitzgerald, M.D., C.M., McGill University. Cloth. Price, $2.00. Pp. 68, illustrated. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

The Treatment of Peptic Ulcer. Based Upon Ten Years' Experience at the New York Hospital. By George J. Heyer, M.D., Professor of Surgery of Cornell University Medical College and Surgeon-in-Chief of the New York Hospital, assisted by Cranston Holman, M.D., Assistant Professor of Clinical Surgery, Cornell University Medical College, and William A. Cooper, M.D., Assistant Professor of Clinical Surgery, Cornell University Medical College. Cloth. Price, $3.00. Pp. 118. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

The Dental Treatment of Maxillo-Facial Injuries. With Supplementary Material on Cases and Techniques. By W. Kelsey Fry, M.C., M.R.C.S., L.R.C.P., L.D.S., R.C.S. (Eng.), Consulting Dental Surgeon to the Royal Air Force; Consulting Dental Surgeon to the Ministry of Health; Dental Surgeon to Guy's Hospital; P. Rae Shepherd, L.D.S., R.C.S. (Eng.), Dental Surgeon, East Grinstead Maxillo-facial Unit; Alan C. McLeod, D.D.S. (Penn.), B.Sc. (Dent.) Toronto, L.D.S., R.C.S. (Eng.), Dental Surgeon, East Grinstead Maxillo-facial Unit; and Gilbert J. Parfitt, M.R.C.S., L.R.C.P., L.D.S., R.C.S.

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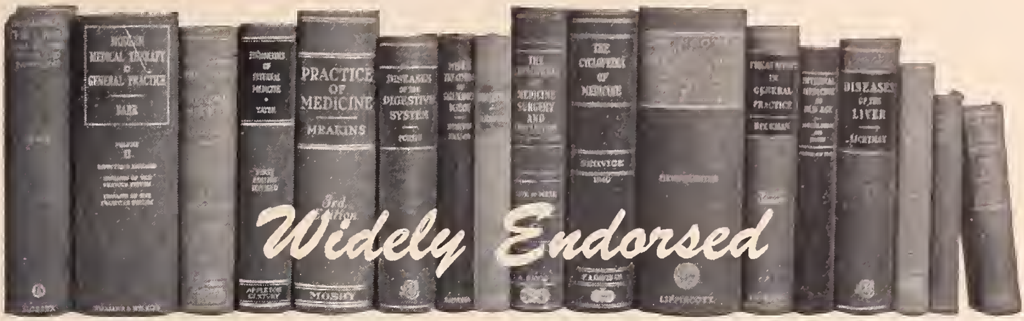

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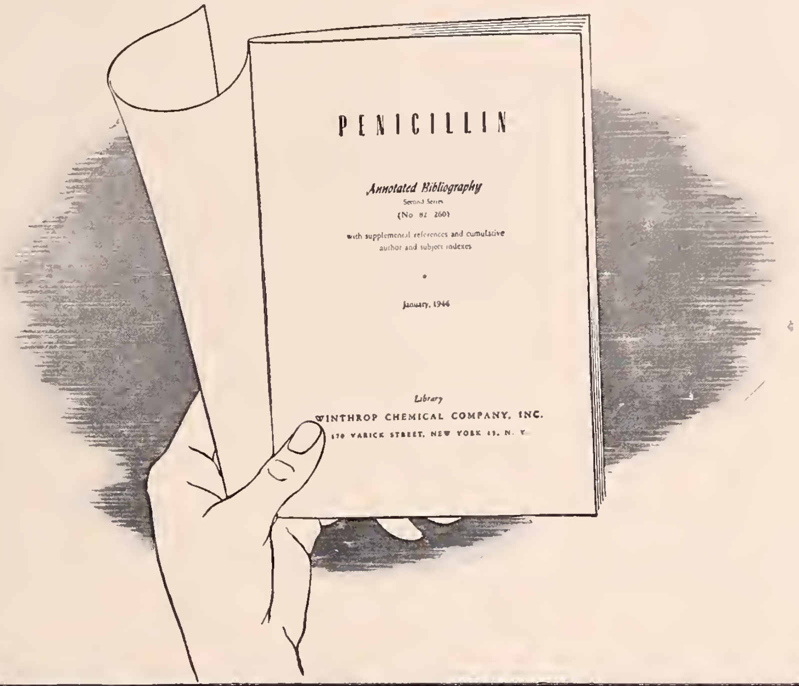
(Eng.), Dental Surgeon, East Grinstead Maxillo-facial Unit. With Foreword by Professor F. R. Fraser, M.D., F.R.C.P., Director General, Emergency Medical Service; and a Section on Fractures of the Middle Third of the Face by A. H. McIndoe, M.S., F.R.C.S., F.A.C.S., Consulting Plastic Surgeon to the Royal Air Force, Surgeon-in-Charge, East Grinstead Maxillo-facial Unit. Cloth. Price, $6.50. Pp. 434, illustrated. Philadelphia, Montreal: J. B. Lippincott Company, 1944.

Radiation and Climatic Therapy of Chronic Pulmonary Diseases. With Special Reference to Natural and Artificial Heliotherapy, X-Ray Therapy, and Climatic Therapy of Chronic Pulmonary Diseases and all forms of Tuberculosis. Edited by Edgar Mayer, M.D., F.A.C.P., F.A.C.C.P., Assistant Professor of Clinical Medicine, Cornell University Medical College, New York City; Attending Physician New York and Memorial Hospitals; Special Pulmonary Consultant, New York State Department of Labor; Formerly Member Faculty Trudeau School for Tuberculosis; Director (ex urbe) Northwoods and Will Rogers Tuberculosis Sanatoria, Saranac Lake, New York; Consultant on Tuberculosis to the Government of Cuba; Board Member of the Finlay Institute of the Americas. With the Collaboration of the Following Contributors: Louis Beardslee Baldwin; Irvin I. Balensweig; Alfred Lee Briskman; William Chang; Anthony C. Cipollaro; William W. Coblentz; Lloyd F. Carver; Martin Dworkin; Earl C. Elkins; John N. Hayes; Ira I. Kaplan; H. Haig Kasabach; Eugene Kisch; Frank H. Krusen; Henry Laurens; Maurice Lenz; Horace LoGrasso; Harriet C. McIntosh; Clarence A. Mills, Leroy S. Peters; Homer L. Sampson, and Stanley L. Wang. Cloth. Price, $5:00. Pp. 393, illustrated. Baltimore: The Williams & Wilkins Company, 1944.

The International Bulletin for Medical Research and Public Hygiene. Editor-in-Chief W. L. Colze. Vol. A44: Rosenow: Poliomyelitis. From the Mayo Foundation for Medical Education & Research, University of Minnesota,

(Continued on Page 16)



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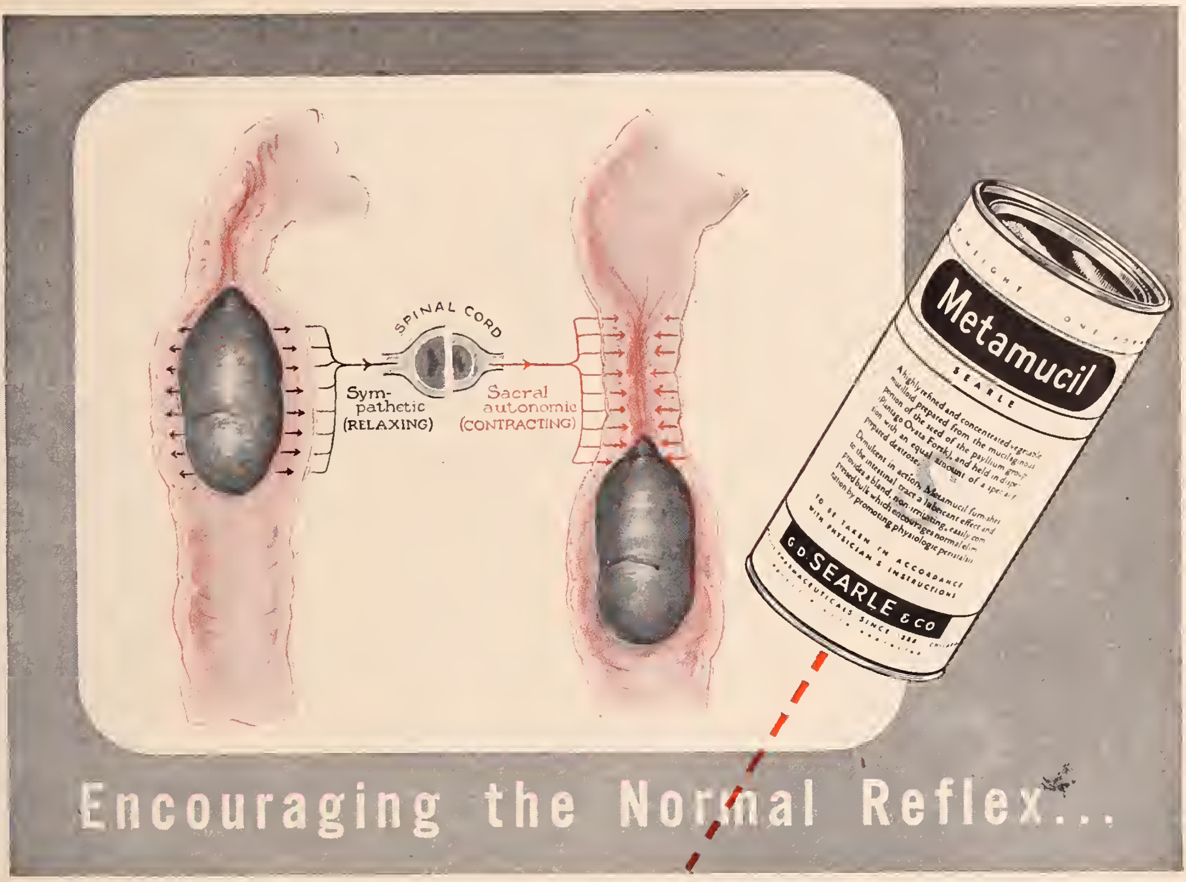
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● New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Sq., New York 17, N.Y.

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Rochester. Paper. Pp. 87, illustrated. Brussels, London, New York: The International Bulletin, 1944.

Principles and Practices of Inhalational Therapy. By Alvan L. Barach, M.D., Associate Professor of Clinical Medicine, Columbia College of Physicians and Surgeons; Assistant Attending Physician, Presbyterian Hospital. Cloth. Price $4.00. Pp. 315, with 59 illustrations. Philadelphia. London, Montreal: J. B. Lippincott Company, 1944.

The Neurosurgical Patient. His Problems of Diagnosis and Care. By Carl W. Rand, Clinical Professor of Neurological Surgery, University of Southern California, School of Medicine, Los Angeles, California. Cloth. Price, $4.00. Pp. 576, illustrated. Springfield, Illinois; Baltimore, Maryland: Charles C. Thomas, 1944.

Medical Education in the United States Before the Civil War. By William Frederick Norwood, Associate Professor of the History of Medicine and Associate Dean in the School of Medicine, College of Medical Evangelists, Los Angeles. Foreword by Henry E. Sigerist. Cloth. Price, $6.00. Pp. 487. Philadelphia: University of Pennsylvania Press, 1944.

The Principles and Practice of Ophthalmic Surgery. By Edmund B. Spaeth, M.D., Professor Ophthalmology in the Graduate School of Medicine of the University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Hospital; Consultant in Ophthalmology, Phildelphia Hospital for the Insane (Byberry); Assistant Ophthalmologist to the Rush Hospital. Philadelphia; Fellow, The American College of Surgeons. Philadelphia College of Physicians; Fellow, the American Academy of Ophthalmology and Oto-laryngology. Third Edition, Thoroughly Revised. Cloth. Price, $11.00. Pp. 934, illustrated with 556 engravings, containing 798 figures and 6 colored plates. Philadelphia: Lea & Febiger, 1944.

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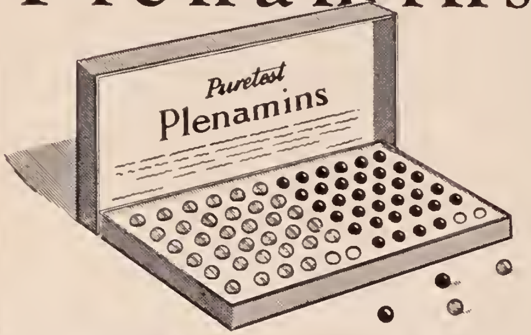

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The Analysis and Interpretation of Symptoms. Edited by Cyril M. MacBryde, M.D. Contributors: Paul B. Beeson, M.D.; Richard H. Freyberg, M.D.; Edwin F. Gildea, M.D.; Sara M. Jordan, M.D.; Sidney A. Portis, M.D.; Leon Schiff, Ph.D., M.D.; David M. Skilling, M.D.; John R. Smith, M.D., and Harold G. Wolff, M.D. Cloth. Price, $4.00. Pp. 1644. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

BOOK REVIEWS

Essentials of Syphilology. By Rudolph H. Kampmeier, A.B., M.D., Associate Professor of Medicine, Vanderbilt University School of Medicine; in Charge of the Syphilis Clinic and Visiting Physician to Vanderbilt University Hospital; with Chapters by Alvin E. Keller, M.D., and J. Cyril Peterson, M.D. Cloth. Price, $5.00. Pp. 518, with 87 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

Among the objectives of the author are the following:

1. To emphasize, that without exception in acute syphilis, a clinical diagnosis alone is not justifiable.
2. To develop a critical evaluation of serodiagnosis.
3. To raise the index of suspicion as to the rôle syphilis may play in chronic diseases years after the infection was acquired.
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5. To emphasize the physician's responsibility in syphilis control does not cease when a patient is placed under treatment.
6. To demonstrate that the education of the patient relative to the disease is an important factor in the control program.

The author feels the problem of syphilis control is obviously not to be managed only by those specially

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

trained in this field, as their number is not adequate. It must be in the hands of the general practitioner or health officer, especially those who have received some postgraduate course in syphilis control.

The sections on diagnosis are well done in spite of condensation. This condensation has been well accomplished and the important items emphasized.

The protean manifestations of syphilis are well described and emphasis is given not only by excellent illustrations but by brief though pertinent case reports. This is well done and adds to the value of the book.

The author is to be congratulated on having compressed an extensive subject into a handy volume that covers syphilis. The book can be recommended to students and practicing physicians.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 48)

after some hesitancy, with the understanding that the speaker might be permitted to outline certain features, rather than to undertake a full discussion of the already extensive subject itself. Recent investigations of the nature of the microbian cause of influenza are sufficiently comprehensive to justify the expectation that one should be able to draw some final conclusions. This, however, is not the case. There still remain many mooted facts which are deprived of their value by conflicting views and hypotheses. If one has read the older literature concerning influenza, it will be found that the discussions which accompanied each epidemic were identical with those which one reads and hears today. . . .

(Continued on Page 22)

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

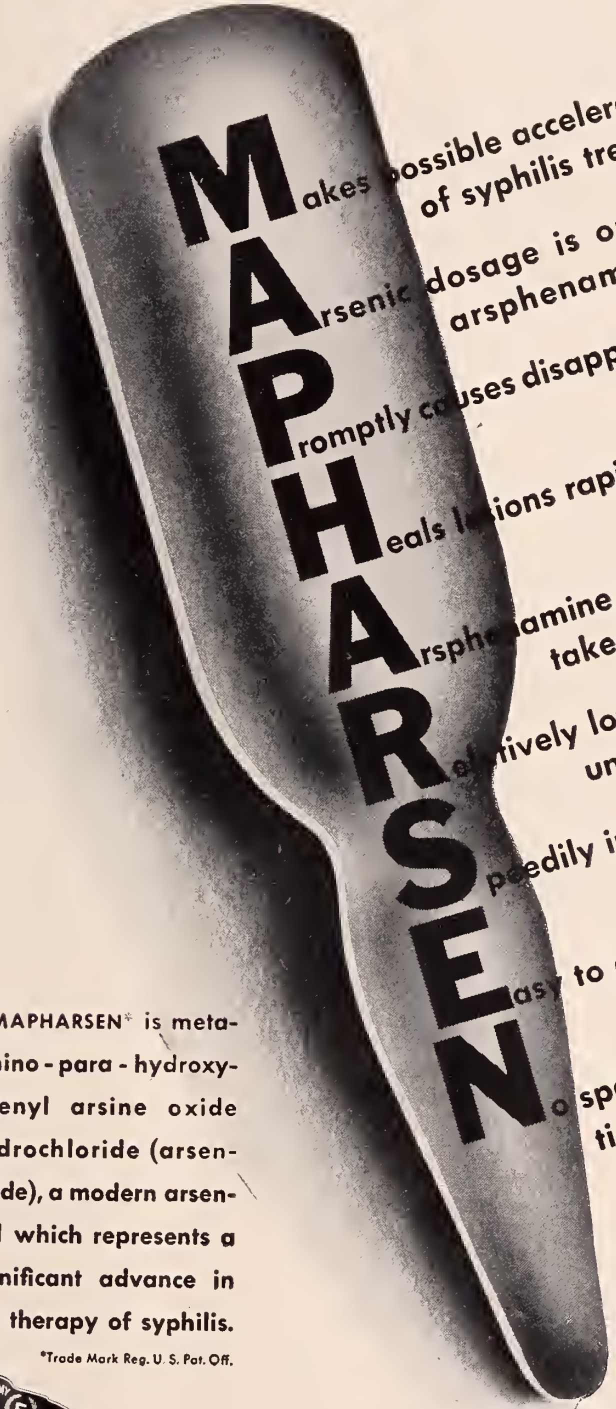
From an Article on "A Report of Influenza Pneumonia Occurring in the San Francisco Hospital under the San Francisco Board of Health—in the Services of the Leland Stanford Jr. Medical School and the University of California Medical School," by Harold P. Hill, A.B., M.D., and George E. Ebright, M.D., San Francisco.—The influenza epidemic in San Francisco occurred in two principal waves—the first beginning October 5, 1918, reaching its apex October 25 and ending November 19. The second wave began November 24, reached its apex January 10, 1919 and ended February 5, 1919.

These two waves gave an opportunity of observing 3422 cases, the great majority of which presented lung signs.

The following report is based on an analysis of 2000 unselected cases. . . .

From an Article on "A Consideration of the Methods Used in the Control of Influenza," by W. H. Kellogg, M.D., Secretary and Executive Officer, California State Board of Health.—Intelligent measures for the control of any communicable disease must of necessity depend upon a knowledge of the cause and mode of spread of that disease. We have learned much regarding influenza during the brief period that has elapsed since its appearance in pandemic form about September of last year, and the outstanding features of our investigations and experiences with this disease are to the effect that we know virtually nothing at all about either its cause or its mode of spread. . . .

(Continued in Back Advertising Section, Page 26)



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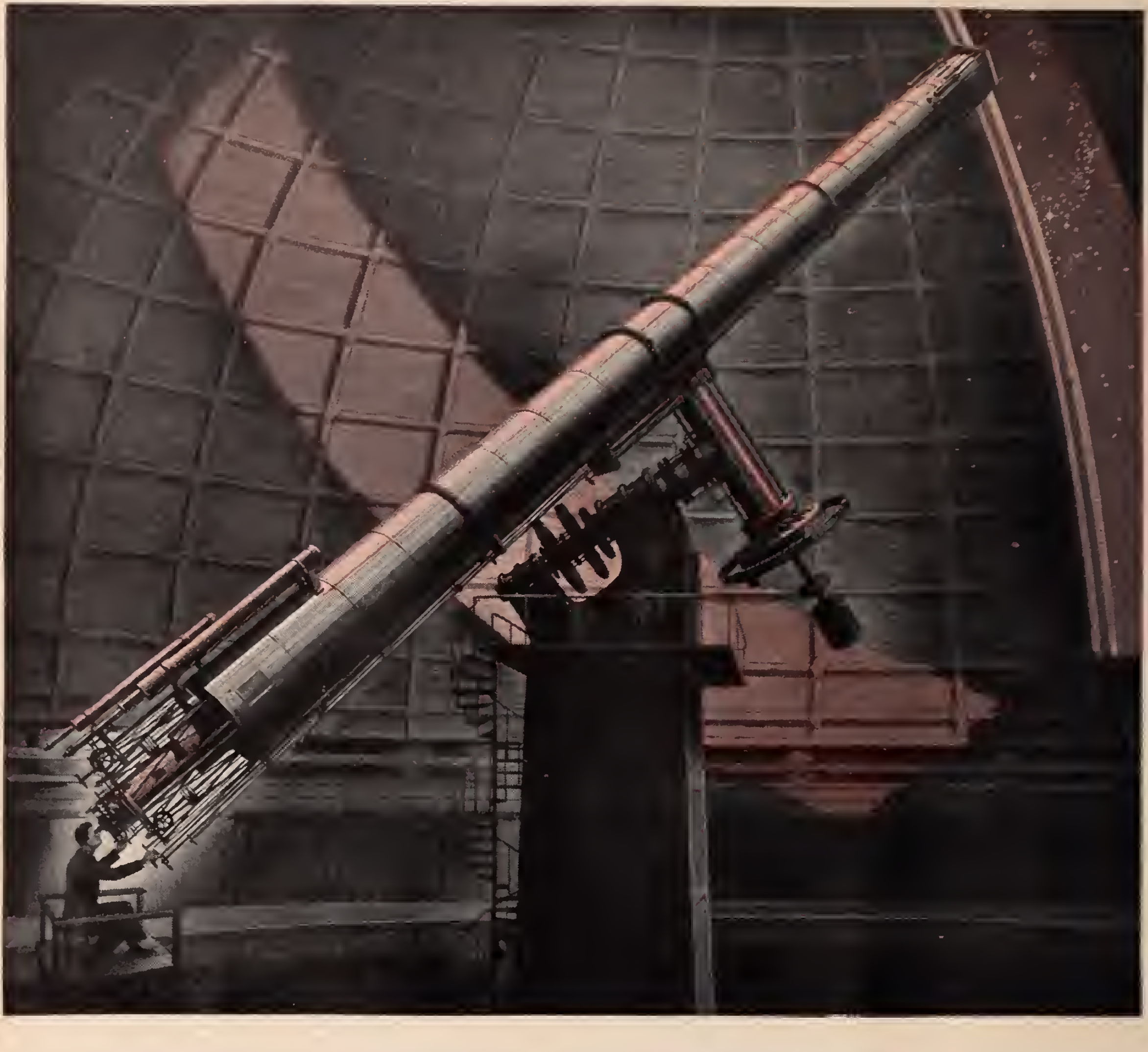

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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EDITOR . . . . GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

Committee on Publications

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George W. Walker (Chairman)..............Fresno 1946
F. Burton Jones............................Vallejo 1947
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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

ON PROCEEDINGS AT RECENT ANNUAL SESSION OF AMERICAN MEDICAL ASSOCIATION

On Inadequate Time for Lengthy Minutes.—Minutes of meetings of the Houses of Delegates of the California Medical Association and the American Medical Association may be assumed to have only casual interest to many physicians. Now that some 50,000 Doctors of Medicine have been withdrawn from civilian practice to take up tasks as officers in the Medical Corps of the Armed Forces, colleagues who remain in private practice have less time than ever to keep up their readings in medical literature. However, because in these days our system of medical practice, long in vogue and worth-proven through low morbidity and mortality records, is being subjected to attacks that imperil its future capacity to render a high quality of medical service, the proceedings of the constituted authorities of state medical societies and the national organization become of increasing importance. Especially, since the Houses of Delegates of the American Medical Association and the state medical associations, acting through their delegates, outline policies and set standards for the various districts and communities. Consequently, since time for reading the detailed minutes of large organizations, such as the A.M.A. and the C.M.A., is not available, editorial comment on some of the proceedings may be in order, particularly for busy members who wish to keep in touch with present organization trends. The source materials for these comments are the June issue of CALIFORNIA AND WESTERN MEDICINE (where incomplete C.M.A. minutes are covered on pages 291-322), and the *Journal of the American Medical Association* which, in its June 24th issue gave pages 563-586, and in the July 1st number, pages 641-660, to a recital of its organization work.

Comment was made in last month's CALIFORNIA AND WESTERN MEDICINE concerning the C.M.A. proceedings, and in the current issue, mention will be given to some of the items noted in the minutes of the House of Delegates of the American Medical Association.

* * *

Distinguished Service Award to Dr. George Dock.—The Distinguished Service Award of the American Medical Association was brought into being in order to honor annually a physician in the United States whose work over the years in scientific medicine or the public health had been so notable that special recognition and appreciation from his fellows should be tendered. Particularly is this desirable, because, under the set-up of organized medicine, these colleagues who are engaged in nonorganization activities are so rarely rewarded with the presidential mantel of the American Medical Association.

This year, the high honor of the Distinguished Service Award of the A.M.A. was conferred on a California physician, Dr. George Dock, of Pasadena. Elsewhere appears the biographical sketch of Dr. Dock, a beloved member of the Los Angeles County Medical Association. He has given devoted service to the upbuilding of the library of that county unit. The members of the California Medical Association join with colleagues of other states in congratulation to Dr. Dock for an honor well deserved. For the biographical sketch referred to, see page 26.

* * *

On Regimentation in Military and Civilian Practice.—A.M.A. Speaker H. H. Shoulders of Tennessee, in his opening address to the House of Delegates, referred to an article in the magazine, *Medical Care,* to which reference is elsewhere made on page 39 of this current issue, and emphasized a fact that should be kept in mind in all discussions of governmental sickness-insurance plans; namely, that while most excellent medical service is being rendered to the Armed Forces by the 50,000 civilian physicians who are now in the Army and Navy,—these military Doctors of Medicine to that extent being regimented,—so also, are the 11,000,000 soldiers, sailors and air force personnel likewise regimented.

However, this fact of military regimentation for one class of citizens, all of limited age group, and mostly men, does not warrant the use of such limited and, in one sense, narrow experience, for regimentation plans affecting civilians, in which men, women and children are equal factors insofar as human life and medical service are concerned, and where the environments of living are altogether different than in the Army or Navy. The paragraph referred to is illuminating in its context and should be read by all physicians. Reference to its basic facts will do away with many unnecessary discussions.

The *Medical Care* article, cited by Dr. Shoulders, also shows how adept are the opponents of existing practice in seizing upon any presumable factor to fortify their contentions. (For references thereto in this issue, see page 39.)

* * *

In Memoriam.—At each annual session of the House of Delegates, the roll of former A.M.A. Officers and Delegates who have passed on, in the preceding year, is given. In the roster of some forty of such A.M.A. Fellows are listed the names of three Californians: Oliver D. Hamlin (Oakland); Frank R. Makinson (Oakland); and William W. Roblee (Riverside). The C.M.A. likewise pays tribute to their past services in both the national and state associations.

* * *

Address of Retiring President James E. Paullin.—Retiring President James E. Paullin, of Georgia, made special reference to *Wartime Graduate Medical Meetings,* such as have been held in conjunction with the American College of Surgeons and the American College of Physicians (a happy and much-needed expression of coöperative endeavor by three influential groups), and emphasized the steps thus far taken in Postwar Planning, as regards continuation, refresher, and other courses for colleagues now in military service. Earnest effort is being made to gather all available information for possible use when colleagues now in Army and Navy come back into civilian practice. Colleagues in military service will be heartened to learn that their civilian fellows are keeping their return in mind.

* * *

Particular attention was also called to an unfortunate directive from the headquarters of Selective Service, through which, after July 1, 1944, the *needed accession of medical students* to meet even normal civilian needs will not be met. This inconsistency by one governmental agency is the more apparent since some other Federal authorities, whose executives have socialized medicine leanings, cannot shout loudly enough, or too often, about the lack of adequate medical care. It is pertinent, therefore, to ask, "From whence is the adequate medical care to come in future days, if insufficient numbers of citizens are to be permitted to acquire that preliminary and medical education and training that is needed to produce an efficient Doctor of Medicine?"

* * *

The *maternity-pediatric* program of the Federal Children's Bureau of the United States Department of Labor also came in for some pertinent criticism. In connection with the E.M.I.C. program, President Paullin stated the problem in good form when he said:

> "Problems of medical care are fundamental to the reconstruction and rehabilitation of our nation. Necessary changes must occur in the distribution of medical care to make it more generally and easily available, and at a lower cost, without the slightest diminution in quality. The medical profession must take the lead in constructively planning these evolutionary changes. . . . The question of sickness insurance on a compulsory or on a voluntary basis is one of the great problems which must be considered as a means of reaching this end" . . .

* * *

The concluding section, however, of Retiring President Paullin's address *is open for debate* as to its practicability. For instance, the sentence:

> "If the ethical principles and conditions of practice established by the House of Delegates are to be successfully supported, state and county medical societies should bring their differences here for discussion rather than place them before the public."

Referring to the above, it may be stated that the members of the California Medical Association in their component county societies and the state association have given many hours of discussion and consideration to a large number of medical practice problems, which to them seemed important. To physicians practicing in environments different from those of California, the topics that have been studied may appear far from important. It should be kept in mind, however, that at an annual session, in the two or three meetings of the A.M.A. House of Delegates, there is opportunity for comparatively brief consideration by the Reference Committees of that House, on matters that may have previously consumed hours and days of discussion in state and component county society meetings; and the A.M.A. Committees' reports, when finally presented, may receive little or no comment. Therefore, it should not be a subject of surprise when the members of the California Medical Association, an organization of more than 7,000 physicians, after expending more than $50,000 of its funds on a medical-economic survey; more than $40,000 in promoting a medical service plan; more than $8,000 on the recent public relations survey; allocating the sum of $18,000 for a Bureau of Information in Washington, D. C.; and expressing its willingness to expend other thousands of dollars in promotion of the objectives of its medical service plans as exemplified in California Physicians' Service, should have concluded they had the right to take certain actions, in case our national organization seemed laggard or unwilling to do so.

Such activities are not an expression of disunity. On the contrary, they show the alertness and interest of the members of one of the largest of the state medical associations, and willingness, over the years, to back up opinions, not by words alone, but also by substantial monetary grants.

The California Medical Association has not been laggard in offering constructive plans to the national organization; as witness, for example, its action years ago in advocating the establishment of the A.M.A. Bureau of Medical Economics. Let us also remember that, when that A.M.A. department failed to measure up in active militant fashion to the objectives and functions originally contemplated for it, the A.M.A. a year ago itself brought into being the A.M.A. Council on Medical Service and Public Relations.

Also, when that newly-created group seemed rather slow in finding itself, the California Medical Association, with several adjoining state medical societies, promoted the United Public Health League, the institution of which in all probability had considerable influence in promoting the establishment of a more active A.M.A. Bureau of Information in Washington, D. C., than would otherwise have taken place.

The soundness of the above statements is borne out in the report of the A.M.A. Council on Medical Service and Public Relations, as given on page 574 of the *Journal A.M.A.* for June 24th, wherein it is recommended:

> "The Council (A.M.A. Council on Medical Service and Public Relations) feels that the work of the Bureau of Medical Economics is so closely allied with its own work, that it recommends that the House authorize the reorganization of the Bureau as a research bureau, and that it be amalgamated with the Council on Medical Service and Public Relations as a subdivision of that Council.
>
> "In furtherance of its recommendations that the American Medical Association take a more active part in encouraging voluntary insurance against the costs of hospital and medical care, the Bureau of Medical Economics under the direction of the Council should be charged with the following duties:" . . .

From the above, the inference may be drawn that the California Medical Association performed a real service for American Medicine when it acted, with some independence, even though in so doing, it was obliged to carry some of its discussion "before the public." Such independence in action, even if "before the public" is not "disunity"; rather, let it be said, it is provocative of thinking and action that may lead to greater unity and success in the attainment of the important objectives sought.

* * *

Address of Incoming President Kretschmer.—Some of the address of the incoming President, Dr. Herman L. Kretschmer, has less appeal than items receiving comment above, since his *recommendations partake of too much optimism and too little realism.*

The American Medical Association reported in 1944 that it had an enrollment of 124,452 members. The Board of Trustees of the A.M.A. consists of nine members, who meet several times during each year. In their brief sessions, those nine men must hand down decisions on many matters of major importance to the Association and to organized medicine throughout the United States. Nevertheless, President Kretschmer ends a defense of the Board—if such it should need—with the statement:

> "The Board is not a closed corporation, as has been alleged; any member of the Association may bring his problem to it."

Therefore, the question may be put: "What would happen if only a few of the 124,452 members should decide to bring their problems to the nine physicians who compose the A.M.A. Board of Trustees?"

ꜜ ꜜ ꜜ

Again referring to the *Wagner-Murray-Dingell Bill,* President Kretschmer says:

> "I should like to call attention to the fact that twenty-four years ago Dr. Whalen introduced a resolution into the House of Delegates on the subject of socialized medicine . . .
>
> "I believe it is incumbent on every physician in this country to devote at least two hours a day to educating the people in his community as to the significance of such legislation, which would result in the deterioration of medical service, limitation in the choice of the physician and increased taxes."

Certainly, Dr. Kretschmer is a super-optimist when he seriously advocates a course of action so absolutely impossible of achievement! Think of it! Two hours a day to be given by every physician educating lay fellow citizens concerning legislation related to medical practice and the public health! In times such as the present, overworked physicians are finding it difficult to secure enough sleep and rest to carry on even the rudiments of their daily work in the care of patients.

From whence would come the two hours for educational work concerning legislation and similar matters? Echo may well answer, "From whence?"

* * *

In his comments on "*Public Appreciation of American Medicine*," A.M.A. President Kretschmer also states:

> "I have always maintained that, except for the smearers, American medicine stands supreme with the vast majority of the people of this country."

President Kretschmer should take time out and ponder on the facts brought forward in the survey on public opinion instituted by the California Medical Association, the Interpretative Report of which appeared in CALIFORNIA AND WESTERN MEDICINE for May, 1944, on page 241. Therein it is stated:

> "But despite this high opinion for the profession (in California), only 34 per cent of our citizens are against federal medicine. In other words, only 34 per cent would retain the system by which they now obtain the services of this profession which they so greatly admire . . . What does this mean in terms of politics? It means simply that 50 per cent of the citizens are definitely in favor of federal medicine; that 34 per cent are against it; and that 16 per cent haven't as yet made up their minds. If it were to come up on the ballot today, you could have only 34 per cent of the votes. You would have to swing to your side *all* of the 16 per cent who haven't yet made of their minds—clearly an impossible task, since generally the "don't know" votes swing to the positive side of the issue (in this case, federal medicine) rather than to the negative side. Even if you could swing all the 16 per cent of don't-know votes, you still wouldn't have a majority. You would still have to convert some of those now in favor of federal medicine. To us it seems abundantly clear that you would lose the issue—perhaps by a landslide."

* * *

Concerning *Scientific Programs at Annual Sessions*, Dr. Kretschmer rightly emphasizes the importance of giving greater time therein to papers dealing with the needs of general practitioners. The sound suggestion is made that about one-third of the papers in each scientific section should be of such nature. Since the majority of physicians are in general practice, their needs should be given prior consideration.

* * *

President Kretschmer concludes his address with the thought:

> "Because the American Medical Association is a scientific and educational body, it will survive in peace and in war, in prosperity and in depression, just so long as it continues to maintain its high standards of educational and scientific excellence."

That the American Medical Association will survive and ever be the recipient of the esteem of patients of its members, there can be no doubt. However, it will be a stronger and a greater American Medical Association, as the years roll on, only in proportion as it recognizes the changes taking place throughout the world, of which our own Country is a part; and adapts its own organization and functions in such wise that its members will be in position to render the highest type of medical service to citizens throughout the land. The American Medical Association must not be content to rest its case on past achievements. Its future is dependent, not on what it has done in days gone by and under other conditions, but rather, on what it does today and what it will do in the tomorrows still ahead.

* * *

A.M.A. Council on Medical Service and Public Relations.—Dr. Louis H. Bauer, chairman of the important A.M.A. Council on Medical Service and Public Relations, submitted a constructive report on medical economics and related problems, comment being made on:

Attempts to unionize employees of hospitals;

E.M.I.C. program;

Bill of Congressman A. L. Miller of Nebraska to have Federal Children's Bureau transferred from U. S. Department of Labor to U. S. Public Health Service;

Recommendation to place the A.M.A. Bureau of Medical Economics under the direction of the A.M.A. Council on Medical Service and Public Relations;

Status of medical officers in Veterans' Administration;

Local surveys to determine whether inadequate medical service exists;

Revision of the platform of the American Medical Association;

Opening of the Washington office of the A.M.A. Council, at 1835 Eye Street N.W., with Dr. Joseph S. Lawrence of New York in charge.

Dr. Bauer was later elected a member of the A.M.A. Board of Trustees. This is gratifying, because it will permit members of that Board to receive first-hand information on vital legislative problems and associated trends.

* * *

Committee on Postwar Medical Service.—Dr. Roger I. Lee of Boston, who received the great honor of elevation to the post of President-Elect, presented the report of the Committee on Postwar Medical Service, and referred to questionnaires that had been sent to physicians in military service, in an effort to secure information to be used in planning and blue-printing on postwar service. At A.M.A. headquarters, an Information Bureau will be established. Referring to postwar planning, with special consideration of the aspirations of the 50,000 physicians who have entered military life in service to our Country, but most of whom again look forward to joining their fellows in civilian practice after the Duration, one of the most heartening addresses given to the A.M.A. House of Delegates in the recent Chicago meeting was that of Major General David N. W. Grant, who, presenting the view of the Air Force department, expressed himself as follows:

> "It naturally follows that you will want the question answered: What about these doctors in the Army Air Forces? What is your postwar plan? I can tell you that, for two years, the office of the Air Surgeon has been working on and revising postwar plans in reference to the doctors who are serving with the Army Air Forces, that these plans call for training or postgraduate study for any medical officer who so desires such training on his separation from the service. I stated here last year, and we still have that policy, that our one aim is to return these doctors to civil life at least as good doctors and, we hope, better doctors.
>
> "I am not prepared at this time to tell you how this will be done, whether in civilian institutions or Army institutions, because from the civilian institution standpoint, legislation will have to be passed. I can only say that it is written into the broad plan of the Army Air Forces today, which covers the medical people serving with the Army Air Forces."

What Major General Grant of the Air Forces has so well expressed in this planning must come to pass. Our national, state, and component county medical societies must dedicate themselves to the achievement of the objectives laid down by Dr. Grant.

No effort must be spared in having Congressmen and the chiefs of the Army and Navy medical corps properly appreciate our obligations to the physicians now in the Armed Forces, whose loyal, generous and self-forgetting professional services are as large, if not a greater factor than any other, in maintaining the morale, not only of our soldier and sailor personnel at home and abroad, but also that of their parents, wives and friends at home. If special action by Congress is needed to attain the ends indicated by General Grant, the medical profession throughout the United States should give enthusiastic support to such legislation. The A.M.A. should outline the program and point the way.

* * *

Comments of Board of Trustees on Coroners-Medical Examiners Problem.—The Board of Trustees, in a supplementary report, gave considerable discussion to the functions of coroners or medical examiners, stressing the need of readjustments in the coroner system that had been transplanted from England into most of the American statutes that relate to these functions. The recommendations submitted are worthy of study by all county medical societies:

> "1. That, throughout most of the country, medicine participates less effectively in the administration of justice in the United States than it does in any comparable country in the world.
>
> "2. That the ineffectual manner in which medical knowledge and skill are utilized in the administration of justice in many jurisdictions of the United States undoubtedly predisposes to:
>
> "(a) The nonrecognition of murder.
>
> "(b) The unjust accusation of innocent persons.
>
> "(c) The improper evaluation of medical evidence bearing on the circumstances in which fatal injuries were incurred.
>
> "(d) Failure to acquire medical evidence which would be useful in the apprehension of criminals.
>
> "(e) Failure to acquire medical evidence essential to the administration of civil justice.
>
> "(f) Ignorance of certain otherwise preventable hazards to public health, and
>
> "(g) The impairment of the value of vital statistics.
>
> "3. *That state and county medical societies should examine the laws that relate to the office of coroner or medical examiner in their respective communities with a view to securing such remedial legislation as may be desirable.*"

* * *

New Business: Re: C.M.A. Resolutions.—Under New Business, among other resolutions introduced, were seven on behalf of the California House of Delegates, presented by Dr. Dwight Wilbur of San Francisco. Two of the seven, dealing with A.M.A. policies, were read by title only, for consideration in a subsequent executive session. The other five referred to:

Creation of a National Department of Public Health;

Transfer of Federal Children's Bureau from the U. S. Department of Labor to U. S. Public Health Service;

Proposal that the A.M.A. institute an adequate Survey of Public Opinion;

Request for Endorsement of United Public Health League;

Resolution on Emergency Maternal and Infant Care.

† † †

The C.M.A. resolutions submitted in executive session, and dealing with functions of officers of the American Medical Association, failed to receive approval, the vote concerning the Editor of *J.A.M.A.* being rejected in a rising vote of 144 to 9.

† † †

Regarding the Proposal that the A.M.A. Institute an Adequate Survey of Public Opinion, it was voted that the A.M.A. Council on Medical Service and Public Relations "may take steps to secure them."

Query? Would it not be wise for the A.M.A. to follow through with a comprehensive survey of public opinion throughout the United States along lines of the recent California survey? Could monies be expended to better advantage?

The California Medical Association has spent much money to obtain first-hand information on public opinion. Why should not the American Medical Association be equally interested and diligent in trying to obtain factual information on what is amiss? Have we not had enough warning on what may be ahead?

† † †

On the Resolution to Advocate a National Department of Public Health. A proposal presented to the American Medical Association as long ago as 1871 by Thomas M. Logan, M.D., then President of the Medical Society of the State of California, later President of the American Medical Association in 1874, advocated a National Department of Public Health, whose Chief would be a member of the Cabinet of the President of the United States. At the recent June meeting, nothing was done by the A.M.A. House other than to reapprove the suggestion. No instructions were given to the A.M.A. Trustees or A.M.A. Council on Medical Service to outline an educational program to bring such a National Department of Health into existence. European nations long have had such departments. With all the modern day hue and cry about the need of adequate medical service, and with Departments of Labor and of Commerce having had cabinet officer representation for years, why should not the health of the citizens be similarly recognized? Our legislators should be made to realize, as was so well stated by Descartes:

> "If ever the human race is raised to its highest practicable level intellectually, morally, and physically, the science of medicine will perform that service."

The House of Delegates of the American Medical Association with good grace, might well have put this objective of a National Department of Health before the members of the constituent state associations as a constructive proposal worthy of early and intense support. Why not give real battle for so laudable an objective?

If our Country had possessed such a National Department of Health during the last ten to twelve years, with trained chiefs and subordinates, it is quite possible, even perhaps probable, that the medical profession today would not be subjected, at Washington and elsewhere, to the vicious attacks that are coming from many angles of the nonprofessional front.

For how many more years must we be content with inaction on this vital objective?

* * *

Congressman Miller's Bill to transfer the functions of the Federal Children's Bureau from the Department of Labor to its proper place under the U. S. Public Health Service was approved. But now the problem arises on how to bring this about. What steps will be taken in regard thereto, and under whose leadership?

* * *

Because the *United Public Health League* came into being in a group of Western States and did not at this time (we quote from the Reference Committee report):

> "adequately represent the remaining 115,000 members of the American Medical Association located in the other forty-two States," it was voted that "this resolution be not approved."

However, as was stated in California and Western Medicine for June, on page 274:

> "Until other agencies give real evidence of fulfilling the service for which many physicians throughout the Nation have been calling, the United Public Health League will carry on its work, with the approval and support of the California Medical Association."

The very important Maternity-Pediatric (E.M.I.C.) program was referred to (page 651, *J.A.M.A.*) as having been "covered in the Report of the Council on Medical Service and Public Relations," which, in turn (on page 573, *J.A.M.A.*) states:

> "These quotations are sufficient to show the trend of the Children's Bureau, and we cannot countenance such propaganda."

Also it was there stated:

> "Inasmuch as the E.M.I.C. program is being reported on at length by the Bureau of Health Education, the Council is making no additional recommendations on this subject."

But when the report of the Bureau of Education is read (see pages 1273-1275, April 29, *J.A.M.A.*) nothing is found in the way of specific advice to the A.M.A. or to physicians! What is there printed is a brief historical digest concerning the E.M.I.C. procedures. From which the conclusion may be drawn that the A.M.A. House of Delegates at Chicago either forgot or side-stepped this E.M.I.C. program that has, and continues to be a source of much major comment and unhappiness to a host of physicians throughout the United States.

Why should not the important principles that are involved in the E.M.I.C. program have received more definite recommendations? Must organized medicine always remain semi-helpless when it is assailed by antagonists?

* * *

For the convenience of C.M.A. members who are interested in organization work, but who, in their busy professional routines of active practice have not the time to wade through detailed and lengthy reports, more comment might have been here submitted. Space, however, forbids. Perhaps what appears in the above thoughts, to be taken for what they may be worth, may be provocation of at least passing or further consideration. If so, the space that has been used may be justified.

Ten Points:

They cost so little . . .
They are worth so much!

1. You cannot bring about prosperity by discouraging thrift.
2. You cannot strengthen the weak by weakening the strong.
3. You cannot help small men by tearing down big men.
4. You cannot help the poor by destroying the rich.
5. You cannot lift the wage-earner by pulling down the wage-payer.
6. You cannot keep out of trouble by spending more than your income.
7. You cannot further the brotherhood of man by inciting class hatred.
8. You cannot establish sound security on borrowed money.
9. You cannot build character and courage by taking away a man's initiative and independence.
10. You cannot help men permanently by doing for them what they could and should do for themselves.

—*Land O' Lakes News.*

PRESIDENT LOWELL S. GOIN

LOWELL S. GOIN
President California Medical Association

Lowell Sidney Goin, M.D., F.A.C.R., was born at Charter Oak, Iowa, on March 3, 1891, graduated from the Charter Oak High School and during the years 1907-1911, attended the State University of Iowa and the University of St. Louis. His medical course was taken at the School of Medicine of St. Louis University, from which, in 1911, he received the degree of M.D. Postgraduate work he carried on at Cook County Hospital in Chicago, and at the United States Army School of Military Roentgenology, Pittsburg.

During the years 1919 and 1920, Doctor Goin was an assistant to Doctor James T. Case, at the Battle Creek Sanitarium, Battle Creek, Michigan, and in further postgraduate work, studied at the University of Frankfort in Germany, from May to September, 1922.

Doctor Goin practiced at the following places: Manilla, Iowa, 1912-1915; Wheeling, West Virginia, 1915-1917 (radiology); Peoria, Illinois, 1920-1925 (radiology), and Los Angeles, 1925 to date (radiology).

He has been and is associated with the following hospitals in Los Angeles: Assistant Radiologist, Santa Fe Hospital, 1926-1929; Visiting Radiologist, Los Angeles Orthopedic Foundation, 1929 to date; Radiologist, and Chairman of Executive Board, Queen of Angels Hospital, 1929 to date.

He is a member of the following: Alpha Kappa Kappa; Los Angeles County Medical Association; California Medical Association; Fellow of the American Medical Association; American Roentgen Ray Society; Chairman of the Board of Directors, Radiological Society of North America; and President of the American College of Radiology.

In the Los Angeles County Medical Association he was secretary of the Section on Radiology, 1929-1930; and a member of the Council, 1930-1936.

In the California Medical Association, he served as Speaker of the House of Delegates, 1937-1942; was President-Elect in 1943; and now is President, 1944-1945.

During World War I, August, 1917, to June, 1919, Doctor Goin served as Roentgenologist B.H.116, A.E.F., 1st Lieutenant, and later as Captain, (MC), U.S.A.

Doctor Goin was married on April 12, 1922, to Margaret Morehead of Salem, Virginia. Two children blessed the union: 1st Lieutenant William L. Goin, U. S. Air Force, and John M. Goin.

PRESIDENT-ELECT PHILIP K. GILMAN

PHILIP K. GILMAN
President-Elect California Medical Association

Philip Kingsnorth Gilman, M.D., was born in Oakland, California, on August 6, 1879. After preliminary schooling at Manzanita Hall in Palo Alto, he entered Stanford University in 1897, and received the degree of A.B. in 1901. In 1901 he worked in the Marine Biological Laboratory, Woods Hole, Massachusetts, after which he entered Johns Hopkins Medical School, receiving the degree of M.D. in 1905, and becoming an assistant resident surgeon in that same institution.

In 1907 he went to Manila, P.I., to assist in the founding of the Philippine Medical School, and became an assistant professor of pathology. Later he was associate professor of surgery in the College of Medicine and Surgery of the University of the Philippines, and served during 1912-1916 as professor of surgery and chief of the Surgical Department. He then became Chief Surgeon of the Philippine General Hospital in Manila, when, returning to California in 1919, he was made a member of the surgical department of Stanford University Medical School. During the years 1917-1919 he was on active duty with the Medical Corps of the U.S.N.R., serving as a lieutenant, being overseas with the Stanford Naval Base Hospital No. 2, which was stationed at Strathpeffer, in Scotland.

Remaining in the U.S.N.R., he became a Commander in the Medical Corps in 1937 and a Captain in 1938.

On July 15, 1941, he volunteered for active duty in World War II, becoming in turn Assistant District Medical Officer, then Executive Officer of the U. S. Naval Hospital at Oakland, Senior Medical Officer in the Office of Naval Officer Procurement in San Francisco, and in 1944 Assistant District Medical Officer in San Francisco, which is his present position.

Doctor Gilman has long been interested in medical organization activities, as is evidenced by positions which he has held: as a member of the Board of Directors of the San Francisco County Medical Society, 1933-1939, being President in 1936; member of the Council of the California Medical Association 1938-1944, being Chairman of the Council during 1940-1944 and becoming President-Elect of the California Medical Association in May, 1944. He is also a member of the Pacific Coast Surgical Association, having been president in 1941; and a Fellow of the American College of Surgeons and a Fellow of the American Medical Association.

In other organizations, he is active as a member of the Bohemian Club; Army and Navy Club; English Club of Manila, and the Butte Lodge Outing Club.

Doctor Gilman has occupied positions of responsibility in a goodly number of social welfare and affiliated organizations, as is indicated by the following: Chairman, Convalescent Care Committee, Health Council, San Francisco Community Chest, 1933; Chairman, Chest Hygiene Committee, 1934-1935; Chairman, Health Council, Community Chest, 1936-1938; President, Public Health League of California, 1938; Chairman, Physicians' Committee, San Francisco Bay Exposition, 1938; Chairman, Public Health Committee, San Francisco Chamber of Commerce, 1938-1939; Chairman for State of California, Committee on Medical Preparedness, 1940; Member Board of Directors, San Francisco Chapter, American Red Cross, 1944; and Trustee, California Physicians' Service, 1944.

Since 1908 Doctor Gilman has limited his medical work to surgery, and has published some thirty articles on surgical topics, with special reference to gastrointestinal and thyroid conditions. At Stanford he was a member of the Delta Upsilon fraternity, and was a member and also a leader of the Stanford Glee Club. At Johns Hopkins he was a member of the Phi Rho Sigma and Alpha Omega Alpha fraternities.

Doctor Gilman has two sons, children of his marriage with Ellen Cary of Baltimore, whose death occurred in 1935. One of the two boys is a physician, being Lieutenant Commander Philip K. Gilman, Jr. (MC), U.S.N.R., and the other being Lieutenant John Cary Gilman, U.S.N.R. Later Doctor Gilman married Emma Shone Fisk of Santa Rosa, their home being in San Anselmo, in Marin County.

EDITORIAL COMMENT[†]

BIOTIN ACTIVATION OF LYSOZYME

An entirely new mechanism of nonspecific immunity is suggested by studies of biotin activation of lysozyme, currently reported by Karl Meyer[1] of the Department of Ophthalmology, Columbia University.

In 1922 Fleming[2] found that certain air cocci are rapidly and completely dissolved by nasal mucus, tears, egg white, sputum and other tissue products. He applied the term "lysozyme" (lytic enzyme) to the active principle in these fluids. This term is now generally applied to several agents that dissolve bacteria other than the test organisms used by Fleming.[3] The original Fleming lysozyme is a basic protein[4] which lyses susceptible micro-organisms (e.g., Micrococcus lysodeikticus and Sarcina lutea) by deploymerizing and hydrolyzing a polysaccharide (mucoid) in their outer membranes. This mucolytic enzyme has been obtained in crystalline form from egg white, and a standard technique adopted for its bactericidal titration.

A second seemingly unrelated basic protein was simultaneously isolated from egg white. This on account of its high affinity for biotin was named "avidin." When it is added to a routine culture medium avidin deprives micro-organisms of essential biotin.[5] Avidin is of more than theoretical interest, since it offers an explanation for the apparent toxicity of egg white when fed in excess to domestic animals. Avidin is practically indigestible and may absorb sufficient biotin from the gastro-intestinal contents to lead to a fatal biotin deficiency.[6]

The relationship between these two basic proteins (lysozyme and avidin) is still a controversial question. Avidin preparations practically free from lysozyme activity have been reported.[7] Laurence[8] reported that while free avidin is practically inert, avidin-biotin complex is bacteriolytic, i.e., it functions as a lysozyme. He believes that avidin serves as a "biotin-carrier" in normal tissue metabolism. Its apparent "toxicity" when given orally is presumably due solely to the large molecular size of the resulting biotin-avidin conjugate, resulting in biotin nonabsorption from the gastro-intestinal tract.

[†] This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

A more detailed study of the interaction between biotin, avidin and lysozyme was undertaken by Meyer.[1] Seven avidin preparations were tested by him against M. lysodeikticus. These showed bactericidal titers varying from 4 to 160 lysozyme units per mg. The addition of 10 micrograms of biotin increased these lytic titers about 4-fold. An even greater increase in bactericidal power was noted on the addition of biotin (1 to 10 micrograms per mg.) to lysozyme. The lytic titer in many cases was increased as much as 250-fold. In the most extreme case an initial titer of 20,500 lysozyme units per mg. was increased to 10,500,000 units (500-fold) by the addition of 10 micrograms of biotin.

No theory is as yet suggested to account for biotin activation of this mucolytic enzyme. It is evident, however, that Laurence and Meyer have opened up an entirely new field of nutritional and immunologic research, which promises results of basic clinical interest.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

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MALARIA

Malaria has always ranked high in the list of pestilences that are a blight to health, efficiency and morale. This disease may in a short period of years injure, and even wreck, a civilization fostered for years. Particularly does malaria effect the efficiency of labor, and the cost through it, to industry, when prevalent, must be enormous. The pernicious "contract" work incidental to tropical areas is a result of industry protecting itself against the loss of time and money, despite the admitted fact that the tolerance for malaria in native populations may be considerable. For instance, the average parasitic rate in blood-film surveys on workers on banana plantations may be as great as 25 to 30 per cent. The importance heretofore attached to enlarged spleen index rates, in adults in the tropics and the Orient, has been markedly discounted by many workers.

Concerning the anopheles mosquito, when of a type that is a potent vector if control of its breeding areas can be obtained, it may be said that malaria would cease to be a disease of importance. It must be recalled, however, that only a few anopheles mosquitoes, after emerging from the larval state, will play an important rôle. This rôle, too, is quite often dependent on the people, their environment and the clinical recognition of the disease with its proper treatment.

This brings to the forefront the distinguishing of a new infection from ordinary relapses—generally a doubtful possibility, except in infants. It is this point that makes the returning soldier and sailor from known infected regions of such importance to the health official of areas proved to have anopheles breeding that are potent vectors. It is an epidemiologic fact that many persons, previously exposed, carry the parasites for years. The elimination of relapses, or the destruction of the parasites in the blood by chemo-therapeutic methods, are still difficult problems. So long as military personnel will be returned uncured, or in a resting or subclinical state, or when true relapses occur, especially in treated persons, or the negative clinically, but microscopically-proved positive parasitic carrier state exists, there must be adopted, in many communities in this country, mosquito control measures. These generally consist of drainage of unnecessary water storage; the treatment of all permanent water courses with oil, paris green dust mixtures, or the new insecticide, DDT, called dichlorodipheynl-trichloroethane, and the use of top-feeding fish; the destruction of mosquitoes in human habitations, and the prevention of access to humans by proper screening; the elimination of migration of mosquitoes by various types of transportation; the proportional degree to which the different species of anopheles are in nature vectors of malaria, and finally blood indices of population groups and their subsequent treatment of those persons found infected.

Let no health official forget that financial and official coöperation are necessary for control, and that there is yet much to be learned to assure eradication of malaria. Moreover, malaria control will continue to play a major rôle in the war efforts of this and other nations.

101 Grove Street.

J. C. Geiger,
San Francisco.

Doctors of Medicine as Others See Them: Health

The Murray-Wagner-Dingell bill with its plans for compulsory sickness insurance would jump the social security tax for both employee and employer from the present one per cent to six per cent. Any kind of insurance works on the principle that more persons pay who don't receive than vice versa. Otherwise all insurance companies would go broke. Compulsory health insurance would mean the well help pay the bills of the sick, which is all right except most persons are able to pay their own doctor and hospital bills. The government has not been able to cure economic ills and we doubt if it can cure physical ills. If adequate provision is not now in effect for health care of those unable to afford it themselves such provision should be made. But it doesn't require a compulsory insurance plan levied on everybody for the benefit of the few.—Kingsbury *Recorder.*

ORIGINAL ARTICLES

Scientific and General

PUBLIC RELATIONS SURVEY OF CALIFORNIA*

JOHN R. LITTLE
Los Angeles

LIKE all the people of California, I have a great admiration for the medical profession. I regret, however, that I cannot come before you today with complete approval of all that you are and all you have done.

Nothing is to be gained by molly-coddling you. If you are to make progress, you must face facts realistically. Therefore, it is my intention to indulge in some very plain talk.

As our patient, we must take you as we find you. And we find your strength being vitiated by very bad hygiene. It is essential, then, that you be instructed, and that is my purpose here this afternoon. I would like to do this as a teacher would instruct a pupil—taking you step by step.

IMPORTANCE OF FRANK APPROACH

Let us start with a major premise. The great tragedies man endures at the hands of his fellows, he often brings upon himself. These are due, in large part, to a failure to heed warnings usually given in ample time. Conversely, his greatest successes with his fellows are attributable largely to the application of a very simple formula—a formula so simple that we are apt to overlook its importance. It is in three parts: (1) heeding the warning; (2) finding the facts; and (3), taking positive rather than negative action. The historians among you will agree that the application of such a formula in human experience is the reaching of new plateaus in accomplishments and prestige.

Recent events provide countless examples of the stupidity and failure of leadership to heed warnings. I would like to give you three very short illustrations. You remember Pearl Harbor, of course. You also remember radar-spotted planes out beyond the Islands; that radar gave a warning and the warning was unheeded. Had reconnaissance gone out to determine the identity of those planes, had the defense forces been marshalled meanwhile, and had aggressive action been taken when the report of facts came in, I am informed by officers of the Navy that the tragedy of Pearl Harbor probably would never have occurred, and the Pacific War might well have been far less costly in life, time, money and national energy.

Second, do you remember the action of business in the '20's? Conservative business leaders and economists issued warnings which were of public record then, and are of public record today—warnings that business was compounding credit almost to the point of national intoxication. Had the situation been surveyed and aggressive action taken in time, the hangover economic headache of the '30's might have been avoided—at the very least, it would have been greatly mitigated. Never again will business be allowed to exercise the authorities and control which it did then.

Third, all of you, I think, can remember how the world of finance has been repeatedly warned over many decades that it must clean its own house, and police its practices and its members. Had it heeded that warning, surveyed its practices and policed its members, it, today, would be controlling its own destiny. Instead, it bellowed with rage. It hurled charges of dictatorship at its critics. It mouthed platitudes about free enterprise, but assumed none of the responsibilities of free enterprise. The result was the stringent securities and exchange law which was imposed, simply because finance itself had proved it was unable to serve the public realistically with control in its own hands. Never again will finance have the privilege of guiding its own destiny.

Leadership, fortunately, is not always blind and stubborn and stupid. There are many examples of leadership in numerous fields which has followed the simple formula successfully. This afternoon I would like to spend a little time telling you about one such leadership. I ask that you study it, as I tell it, to see what parallels you may find to your own case.

A RECENT CALIFORNIA PROBLEM: METHOD OF APPROACH

In 1935, the Legislature of this State passed a Chain Store bill and the Governor signed it. It was a discriminatory tax so punitive it would have put the chain stores out of business. The antichain store forces were united, strong and vocal. The chain stores were highly competitive and disunited. It came as a great shock to them that the people who benefited most by chain-store operations were apathetic to their cause and, indeed, large numbers of people were actually hostile. It came as a shock to them, also, that farmers and purveyors to their business were apathetic and, in many instances, were hostile. Chain stores had forgotten the fundamental public relations truth: you have to be more than right, you have to *seem* right.

They hired our organization. We surveyed the facts, and under our guidance they took positive action. Their last recourse was to the people themselves through the referendum. There was only a year in which to achieve success. And for seven of the twelve months there was no surface indication that anything was happening. Actually, the most important part of the campaign was under way, for they were cleaning house and they were making friends by demonstrating friendliness.

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* Address to the C.M.A. House of Delegates at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944. Report and recommendations of Foote, Cone and Belding. For reference in minutes of H. of D., see CALIFORNIA AND WESTERN MEDICINE for June, on page 293. An "Interpretative Report" by Mr. Little with other references, appeared in CALIFORNIA AND WESTERN MELDICINE for May, 1944, page 241.

The first job was to survey their personnel policies. No one is more important than the man who comes in contact with the public. It was discovered that their own employees were not sold on chain-store operations simply because no one had ever bothered to acquaint them with the facts. (You should find this significant.) The cure for this was a simple remedy. They held meetings for their employees at which short lectures and, especially-made motion pictures, were shown to prove the rightness of chain-store operations. Soon buttons began to appear on the lapels of clerks giving their names. Special insignia testified to long and faithful service. Many situations were gone into. Where injustices were discovered, salaries were revised upward. It was not long before employees became conscious that the big bosses were mightily interested in them, and were very susceptible to suggestions. The principle is—and I ask you to apply this to yourselves—*no organization can long be successful unless those of its members who contact the public are enthusiastic about it.*

Chain-store managers joined the local Chambers of Commerce, Rotary Clubs and other service clubs. Donations to local charities, which formerly came from chain headquarters, were dispensed by the local manager. Soon these managers were important in their communities. The Boy Scouts and other organizations became aware of the importance of the chain stores to their existence. Yet the total of the donations was not increased. In each community chain-store managers formed clubs. They surveyed their own towns for sore spots, and saw that the facts were given, the sores healed.

In the meantime, the farmers were surveyed. Why didn't they like the chain stores? We only wanted to find the facts, not to sell them anything. Mostly, we found misunderstanding; but where practices were faulty, they were corrected.

Most important of all, the big operators met with the farmers and learned, first hand, their problems. Then they devised ways to help them. Soon chain stores were conducting drives to move surplus crops. For example, a tremendous peach crop was moved very rapidly. All chains who could coöperate did so—from drug store soda fountains to grocery stores. As a result, the crops were not only moved, but the farmer received higher prices for his surplus and the chains themselves profited greatly. The principle is: *when you work, hand-in-hand and sympathetically with those who seemingly are against you, both of you can profit in the long run.*

All other groups upon whom the operations of the chain stores impinged, even banks and newspapers, as well as food producers and suppliers, were similarly surveyed and educated. New policies were created, when necessary.

When the chain-store house was cleaned, we went to the public. We took the *new* story of the chains to the people. Resolutions of support came in from hundreds of organizations, not only in California but throughout the nation. In a campaign notable for its vigor and scientific controls, the anti-chain store forces were badly whipped. Incidentally, our polls predicted the final vote within one-half of one per cent. In other States we conducted similar campaigns and whipped the anti-chain store forces. Chain stores then requested we meet with chain-store operators, nationally. The result was that, universally over the nation, the chain stores took the blueprint that was made right here in California and applied it to themselves. Never since that time have the anti-chain store forces raised their hands.

MEDICINE MAY BE FACING A SIMILAR PROBLEM

Something of this nature is happening with medicine in the State of California. And I think we may look forward to a like result. First, your Council has heeded the warning. Instead of looking to opinion among the membership of this organization—opinion which frankly runs the gamut of views of 30 years ago to that of the lunatic fringe—it hired an organization to find the facts. This organization, incidentally, spends thirty to thirty-five million a year of its clients' money to guide their destinies in such ways as these. Second, *we* have taken the next step for you. *We* have found the facts.

Today you are met here to determine whether or not *you* will take the third step. The third step, you will remember, involves taking positive action by (1) putting the house of medicine in order in this State; and (2) taking your story right to the public. We cannot force you to take this third step. Indeed, we would not if we could. But I think you will note an interesting parallel between our professional relations with you and your relations with your patients. I am sure you have had many experiences with patients in which you recommended treatment only to have the patient fail to follow your suggestions. If so, you will appreciate our position. We know, through vast technical experience and a very careful study of the facts surrounding this case, just what will cure the malady of Federal Medicine. But whether you will be a good patient or a bad one, we will not know until you, yourselves, have made up your minds.

PROBLEM CAN BE SOLVED

It is our opinion that problems far more complicated than yours have been solved. We do not believe any sleight-of-hand is necessary to solve this one. It is purely a matter of common sense, of facing facts realistically instead of rebelling against them, or hiding in panic behind a mask of disbelief.

Personally, gentlemen, I have grown weary of hearing it said: "The doctors can never get together; they never can act in unison." I submit this is merely a defense mechanism.

We are well aware that doctors are individualists. We know they are trained from medical school on to trust their own judgment implicitly. It is essential they be so trained, for they may find themselves with a serious operative case far from any operating room, proper instruments or trained assistants.

We know, too, that within their own world, doctors are supreme. Their word is law. And they are accorded the deference due their importance. Even women nurses step aside when the doctor gets into an elevator.

Furthermore, doctors are used to almost complete approval. Doctors only see satisfied patients, as a general rule. The dissatisfied ones seek another physician. The result of this constant approval, too, further convinces the doctor of the rightness of his opinion and his judgment.

Unfortunately, the demands of the profession require that doctors spend their lives within a very narrow sphere. Largely they come in contact only with people who are sick. Their social hours are spent mostly with other doctors. And even within their own profession, they are limited to the local viewpoint of their colleagues. Only a few of them (like yourselves) have the advantage of a commingling of opinion with doctors from other sections of the State or Nation.

I had reported to me two days ago a rather horrible example of the application of this local viewpoint. A member of a very important hospital committee, charged with the responsibility of representing hospitals on a very vital matter with a committee composed of some of the officers and leaders of this Association, 'phoned a few of the doctors in his own community who happened to be friends of his. "Are the doctors actually going to change C.P.S.?" this hospital man asked, "or is all this hullabaloo just a lot of eyewash?" "Just eyewash," reported his friends, "don't be fooled by it."

How very tragic! How devastating in its destructive power to the best interests of medicine in this State! It is true that the local doctors had not been acquainted with all the facts at that time. The point is, however, they did not even think it necessary to check and find the truth. They depended completely on their own opinion and the local viewpoint of their colleagues. Who can say what damage such thoughtless talk might do? How badly it might sabotage one of your most important programs? I rather suspect that those doctors would be shocked if the tragic implications of what they had said were explained to them.

With all these circumstances surrounding the career of the doctor, is it any wonder that the opinions of your members are so divergent? Recently in this city I put myself through the fire during a question period to learn the extremes of viewpoint among a large proportion of the delegates here today. In your interest I wanted to discover what these viewpoints were and what motivated them. I found out to my complete satisfaction. For several days I was rather depressed by what I heard, and then, when sound judgment returned, I realized that those men were merely rebelling against something they feared and did not understand—which, we must admit, is rather normal human behavior.

In general, they sought a scapegoat for the current ills of medicine. They found two rather innocent ones: the public and legislators.

CONCERNING FEDERAL MEDICINE

If there is any one thing I must do here this afternoon, it is to convince you of one vital truism. You simply must get the thought completely out of your mind that Federal medicine can be *imposed* by anyone, by a pressure group like organized labor, by politicians, or by any administration, Republican or Democratic. Many of you fail to understand that the Government is only a means (and historically the last resort), by which the people get what they want when they cannot get it any other way.

Please get this straight: The people do not *want* Federal medicine. They only want what they have been told *will result from Federal medicine*. The pressure groups and the politicians cannot enact Federal medicine without the clear will of the people. These are not just words. This is the crystal truth, as understood by any 16-year-old political science student. If the people, for example, thought a monarchy would serve them better than a republican form of government, not all the pressure groups and all the politicians could prevent it. What the people want they will *ultimately* get. The people want everyone to have the benefits of scientific medicine at a cost the lower income groups can afford without financial catastrophe. I suggest you rid your minds completely of any consideration of politicians, pressure groups and administrations; that you think only of what instrumentality *you* can supply which will satisfy the peoples' wants —an instrumentality which will be superior to anything the politicians can offer. I am sure Mr. Ben Read will support me completely in this advice.

Most of the other divergent and extremist viewpoints come from misunderstanding. Judgments and opinions are being formed from incomplete information. It is no wonder such judgments are faulty. Why is the information incomplete? The answer is very simple. The doctors of this State are very busy men and women. If my observation of a few can be applied to the whole, the medical desks in the State of California are piled with staggering heaps of medical journals, Medical Association bulletins and reports—very largely unread. I have no doubt the report sent out by your Council on the Survey has not yet been thoroughly read by a number of the Delegates here.

Regardless of all this, the truth is that the doctors *can* act in unison. But they will not do so unless they get *all* the facts. The common danger, when clearly understood, will impel them to united action—just as it does all groups whose leaders heed the warning. The plain duty of you men and women in this hall is to see that the members in your own districts get fully acquainted with the truth. Like the chain-store managers, *you* must heal the sore spots.

There is already a substantial majority of supporting opinion to which you can point. But since you are dealing with doctors, I would not use it. The *truth* is a far better tool of conversion Once you have made a convert out of an essentially honest man, you have gathered the strongest adherent into your fold. For the honest man who finds he has been wrong, like the reformed drunkard, is the most eager to convert others.

Acting in unison is nothing more than team play. True, it takes a kind of spiritual guts on the part of the individual to put aside his interests for the sake of the team's objective. Doctors, however, seem to have a highly-developed spiritual and esthetic quality. Once they learn the joy of team play, as a few of you have, you may expect to see them in the thick of the battle using their highly developed intelligence and tact to disarm the enemy and render him harmless.

ON POSITIVE, RATHER THAN NEGATIVE ACTION

We have said that the third step: taking positive rather than negative action, involves two moves: (1) cleaning house; and (2), taking your story to the public. You may wonder specifically what is involved in cleaning house. I should like to tell you. First, *you must unify the profession in this State.* If you cannot throw the weight of a majority of your people behind a united front and then set up the machinery to meet the demands of the public, the people will desert you for a political panacea. Your problems of unification are no more serious than those of other groups. These are merely *different* problems. The machinery which you set up is the voluntary prepayment plan. The public will accept it as preferable to Federal medicine. But the plan which you set up must be so conducted that the whole profession will rally to it, will support it enthusiastically—otherwise it is no weapon.

Mr. Ebersole (at the request of the Council) and I have contacted about 75 per cent of the membership throughout the State—Mr. Ebersole by a very wide margin doing the lion's share. We found no basic oposition to the prepayment plan idea. The opposition—and it is formidable —is to *this* prepayment plan which you now have. It is important, then, to show the membership that there is a clean cleavage between what has happened up to this date and what will happen from now on.

How shall you make that cleavage? We suggest that you start thinking in terms of what your prepayment plan must develop into. You must be prepared to cover between three and five million people in this State very rapidly. We don't believe you have realized the immense size of the corporate structure which must be built. (The one you now have, grossing a million and a quarter dollars annually, is pretty good-sized; but it is a baby compared to what it should be.) Furthermore, it must be built on the finest standards of American business. As we have said before, you are no longer individual entrepreneurs only. You have the trusteeship for a great commercial operation. In that operation the doctors of this State must take a justifiable pride. Frankly, many of them are ashamed of it.

EXPERIENCED LEADERSHIP NECESSARY

Building such a structure quickly is not a matter of magic, but neither is it a job for busy doctors. It requires a leader who can command and maintain the confidence of the rank and file. It requires a man with the experience and ability to evolve a reorganized and expanded plan. Such a man must be as thoroughly trained in his field as you are in yours. He must be experienced in sales and marketing, finance, public relations and in general corporate administration. There are a lot of good amateurs on the fringes of the medical world. But if you want a man to inspire your membership, the staff, and the public, it requires more than an amateur. We think it safe to say that the men in the medical world are largely amateurs in business. What you need is a *professional* business man.

We were not instructed to investigate your present plan, the California Physicians' Service. The public and the doctors are our only source of information. However, we do know you have hired departmental specialists difficult to replace. I have been told Dr. Larsen, for example, understands thoroughly what values the profession wants to maintain. It will be a tremendously important job under the general administrator to see that these values *are* maintained. You have other specialists, like Mr. Ebersole, with whom I have been deeply impressed, and still others I do not know as well but who must be highly experienced and valuable in their own special fields.

What you lack is the overall leader: to coördinate the activities of these specialists; to make general plans and assist them with their own planning; to inspire them and you; to create policies, subject to your approval, of course, through which to achieve your objectives.

In solving the problem of unifying the profession, the services of such a leader will be invaluable. For the problem of unification is very largely one of education. The educational campaign among members (which, incidentally, will never be concluded), can be placed squarely in his hands. Such an assignment will produce no terror in him.

Your second job in cleaning house is to improve your public and professional relations. In discussing this, let me assure you our judgment has not been influenced by anyone. We are accustomed to pressure. Actually, I have been surprised at the lack of pressure and you might be interested to know that no officer and no member of this Association had any prior knowledge of what I was to say here today or what recommendations we will make to you.

A PUBLIC RELATIONS PROGRAM

The first part of your public relations concerns the interrelationship of your own members and also the relationship of leadership to them. In general, your membership is divided into the three groups, common to any association. First, those who are actively in favor of your program for organized medicine in this state. Second, those who are against it by virtue of honest convictions. And third, the scoffers or the "aginers" who are against any program no matter what it is.

Don't spend any time on this latter group—it is time completely wasted. Spend all your time with honest men. Take the trouble to sit down with them in a friendly manner. Perhaps, they have something to contribute. Or they may not know the facts. The probability is, however, that they are quibbling about details and missing the forest for the trees. (This is often the great indoor sport of doctors when discussing problems of public relations and pre-payment plans. They argue about details and miss the main objective.) But if you are open-minded and can discuss the problem without rancor, they will be open-minded too, and you will reach a satisfactory agreement.

The second part of your public relations program concerns relations between executives of the Association and county groups, and the intermural relations between county groups themselves. I think it is a truism that, when you question the marital status of any man's parents, you make an enemy of him. When a county society fails to support the general program don't swear at it. Nor can you trust the mails. If you send a delegation of responsible leadership to determine the cause of the difficulty, not a "take-this-or-be-damned-to-you" delegation, but a *fact-finding* delegation schooled in the common sense of public relations, it too probably will learn something of great help to the whole Association. But this result cannot occur if the marital status of all the parents of all the doctors in this society has previously been questioned. It takes a long time to make a friend out of an enemy. During that time you can expect such a society to take great glee in thwarting your plans, no matter how admirable or how meritorious they may be.

There is not now any situation in the State half so desperate. But there have been. You must not allow any more. It may require throttling those individual members common to any association who speak their own narrow viewpoint with cutting brutality, and who pretend that theirs is the viewpoint and the philosophy of the group.

We are quite safe in reporting to you that among those very few counties where there has been trouble in the past, the majority of the leadership is now ready for the peace table. If, in meeting with them, you recognize there must have been a real reason for their anger in the first instance, there is no mutual problem that cannot be satisfactorily solved.

The third part of your public relations program concerns your relations with hospitals and the Blue Cross Plans. Speaking for myself, nothing has given me greater concern than the policy which you will ultimately evolve. Please remember that, as far as the public is concerned, the problem of medical care involves both the doctors and the hospitals and, indeed, everything which contributes to the high cost of medical care. Therefore, the hospital problem is of paramount importance to your cause.

Hospitals will sooner or later realize the threat to their existence as plainly as you do. When they do, they will wish to guide their own destinies completely. No one ever appreciates a privilege as keenly as when he is about to lose it. If hospitals insist on autonomy, as they will (as some now do), they will fight with vigor any group like yours if it insists on controlling their own services or any part of them.

FEDERAL LEGISLATION

In Washington the Murray-Wagner-Dingell bill lies in committee. As we said before, it probably will stay there. But, as Mr. Fulton Lewis has pointed out, there will be other Murrays and other Wagners and other Dingells, who will bring forth other bills more subtly drawn to place control of medicine in bureaucratic hands You should remember there is no vote-getting device so efficient as the one which—posing as purely humanitarian—offers the people something they do not have, but want very much and believe they can get in no other way.

The promoters of such bills have only one serious obstacle: groups like yours which will provide something better than the politicians can offer. Their only hope in defeating you will be to impeach you, to point to your errors as proof that control cannot be left in your hands. If the doctors and the hospitals get into a fight you will provide them with precisely the ammunition they want. Therefore, amicable and increasingly sympathetic understanding between doctors and hospitals is worth anything it costs. The current threat to such an understanding is what you do concerning the method by which hospital coverage is obtained by the California Physicians' Service.

STATEWIDE HOSPITALIZATION COVERAGE

We recommend that you continue your relations with the three Blue Cross Plans in the State until such time as you can deal with one which has state-wide coverage. Some of you will object to this. Some will say that hospitals do not now control two of the Blue Cross Plans. This is true. But the hospitals must ultimately, in their own interest, take responsibility for these plans. The whole trend is now in that direction. Your plain duty, we believe, is to exhibit patience despite conditions which may antagonize you. Nothing will have more influence upon the hospitals than your own attitude. And you can speed the day by your encouragement when a satisfactory situation will be developed for you.

Please remember, also, that the Blue Cross Plans are not yet sure of *you*. Remember, too, that the total of their membership is distinctly ahead of the membership of your own plan. When you have more in numbers than all of theirs combined, you will be in far better position to expect complete coöperation and confidence.

SUMMARY

In conclusion, let me boil all of this down to practical steps upon which you can take decisive action at this or subsequent meetings. Here are our recommendations:

1. That you hire a splendid business executive administrator; that you recognize there are men who can get the job done of covering several million of people at low cost and at high speed.

Such a man is not Dr. X.Y.Z.'s neighbor. He is a man whom you will pick because of his national standing. You cannot and must not accept any less. He is a man of business—not of medicine or an allied profession. Big business long ago adopted the policy of not worrying about an administrator's technical knowledge. He can get all the technical knowledge he needs from the executives under him.

For example, when the Union Oil Company needed a president, they chose Mr. Reese Taylor. Mr. Taylor was president of a steel company. The oil business is highly technical and Mr. Taylor had no training in it. But he was, and is, a splendid administrator. Mr. Taylor has only to consult his departmental specialists—his geologists, his chemists—for whatever technical information he needs.

Only by getting a professional business administrator can you circumvent the dismaying problems which will otherwise face you. But a man with the "know-how" of handling business and administrative problems can make life easy for you and lead you quickly to your objectives. We recommend the immediate employment of such a man. If you need help in obtaining candidates for the job, we shall be happy to suggest several.

2. We recommend the formation of an organization to deal with your members and member societies throughout the State, so that everyone of your members can conscientiously decide the extent of his coöperation on the same full information your Council has for its own decisions.

Stated in other words, this means the establishment of a public relations department, and at once. We recommend this department continue working under the Council until your executive administrator has been appointed and is at work. Then it should be transferred to his control.

We are well aware that you would like to settle all details of personnel and policy at this meeting, but you could and probably would go wrong again. There are at least 50 men in this room who know precisely what is the matter with C.P.S. They are loaded with details and the opinions of their patients. Yet no two of them will agree with each other.

One of the duties of your new executive, ladies and gentlemen, will be to direct the detail and the policies of C.P.S. As busy doctors this is no job for you. For your own sakes, keep looking at the forest and not at the trees.

This public relations department can commence the public relations program I have outlined and it can start assisting in the job of unification. It should be headed by a layman, and the Council should appropriate sufficient funds for it to function effectively in its field. We respectfully suggest that this be done immediately.

3. We recommend the division of all councils, both in this Association and in the several county medical societies, into three groups, responsible respectively for: 1, the progress of scientific medicine; 2, medical economics; and, 3, public relations.

These are actually the most important functions you have. You have neglected the last two, namely, medical economics and public relations. Now they are of vital importance to you and must be neglected no longer.

If the counties are divided into these groups, the men whose specific talents fit any one of the three will naturally gravitate into the logical group for them. Such a grouping will serve a fundamental and invaluable purpose: it will develop trained leadership in each of these fields. When, for example, your house is cleaned and it is necessary for certain of your membership to sit down with labor, management and agriculture, you will be represented by doctors who have had training in the job they are doing for you. When it is necessary to contact and convert to your cause all public groups like the many State associations, the Rotary Club, Chambers of Commerce, and so on, again you will be splendidly represented by men whose natural aptitudes and training qualify them for this job. Lastly, the public relations group of the County Councils will be the liaison through which the new public relations department will work.

These three recommendations may seem rather simple and somewhat obvious. If they were complicated we would be suspicious of them. They represent, as far as we are concerned, all the treatment you are ready for at this time. If your body was whole, so to speak, we could give you much more. But until you are unified in thought you cannot be unified into a tremendous program. These three recommendations represent the *method* by which unification and house cleaning is to be quickly accomplished. When this job is done, then and then only will you be ready to go out with a public program to get capital, labor, the farmer, and the people solidly behind you. That is the time when you will take your *story* to the people. That is the time when we suggest you again call upon Foote, Cone and Belding, or other competent counsel. Then advertising and all the tools of mass selling can be united into a mighty program. You do not need us until then. The money which you would spend to retain us for the intervening period had better be put into a war chest for future use.

IN CONCLUSION

Now, your real problem is to gain strength and unity from within yourselves. You have a long way to go. The problem of whipping Federal medicine, in our viewpoint, is far less difficult than the chain-store situation and others of recent memory. The weapons are at hand. All that has been lacking so far is the will to fight—not on the part of your leadership, but on the part of the rank and file. All that is lacking is the stamina to adopt a common viewpoint, to accept the facts realistically.

We want you to visualize medicine on the move—a militant, united medicine. You have the power to make the move that will thrill you and the people of the State. Imagine every Rotary Club, Farm Bureau, newspaper and all of the people being told of this militant move of a united medicine to solve a great human problem.

Imagine the whole State organized into a great coöperative campaign under your leadership.

Imagine, if you will, the repercussions on each community, large and small, as this story is told—a story not duplicated elsewhere in the nation up to that time.

Imagine, the effect of this on your colleagues who will return from the War. Undoubtedly, they will praise you for *carrying on,* instead of *hanging on.*

Imagine the blueprint you will be making here in California for other States to follow.

Yes, ladies and gentlemen, responsibility is a twin and the name of its brother is opportunity. They go hand in hand. Seize then both the opportunity and the responsibility. We promise you, of course, difficulties and heartbreak, but also thrills and satisfaction such as you have never before experienced.

And we hold out to you a result which will crown your careers with new dignity and new prestige.

Thank you very much. (Applause.)

601 West Fifth Street.

Industrial employment must be deferred for job applicants with active tuberculosis. Since the employer has an obligation to the community with respect to rehabilitation, activity or tuberculosis lesions developing during employment should indicate a furlough for treatment; not termination of employment. The criteria for the recurrence of activity should include not only roentgenological evidence, but also increases in sedimentation rate or febrile reaction. Although these patients might not be passing infection to others at the time, employment would be against their own best interests and a serious potential danger to others.—Wayne L. Rutter, M. D. and J. W. Dugger, M. D., *Indus. Med.,* Jan., 1944.

CARBON TETRACHLORIDE POISONING*

REPORT OF CASES

COMMANDER B. E. KONWALER
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AND
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WORKERS in industrial medicine have long been aware of the potential dangers from carbon tetrachloride when used either as a solvent or a cleaner. Nevertheless, in the ten year period prior to our entrance into the war, the production of carbon tetrachloride almost doubled. Since that time its production and use have undoubtedly increased, probably because of its cheapness, availability and efficacy as a fat solvent. Consequently, cases of harmful exposure to the volatilized liquid have increased proportionately.

The dangers from this chemical have been found to be more serious than previously stated. Thus Elkins[1] has found symptoms of poisoning developing in employees even after exposure to a concentration of twenty-five parts per million. These employees were engaged in dry cleaning, spotting, multigraphing or coating, and complained primarily of nausea. Elkins concluded "that 100 parts per million usually recommended as the maximal allowable concentration for carbon tetrachloride is too high and that the correct value is not above 50 p.p.m. and probably not below 25 p.p.m." In June, 1942, Ashe and Sailer[2] reported a case of fatal uremia following a single exposure to carbon tetrachloride fumes. Their patient had been exposed for four hours while cleaning machinery in an elevator shaft. In October, 1942, Perry[3] reported 88 cases occurring among soldiers who were engaged in cleaning their newly issued service rifles with carbon tetrachloride and who were working in the downstairs back-room of a closed two-story army barracks. Of the eighty-eight cases, two terminated fatally. In April, 1943, Captain M. D. Willcutts (MC), U.S.N.,[4] reported three cases occurring among twenty members of an engine room crew who were working in the same room in which another group of men were cleaning the generators with a carbon tetrachloride spray. The men operating the spray guns wore masks and worked in two hour shifts. Of the three cases among the engine crew, two terminated fatally. McNally[5] has collected reports of more than sixty cases of carbon tetrachloride poisoning, twelve of which ended fatally.

The purpose of this report is three fold: First, to add three more cases of poisoning resulting in

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* Read before the Third General Meeting at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

The opinions or assertions contained herein are the private ones of the writers and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at Large.

one death; second, to review the various factors which apparently increase the susceptibility to poisoning, and third, to report the clinical pathology and necropsy findings.

POSSIBLE SYNERGISTIC FACTORS

It becomes apparent from a study of the cases reported in the literature and from our own cases, that various factors may play a synergistic rôle in causing poisoning by carbon tetrachloride. These include (in probable order of importance): Consumption of alcohol, excessive exertion, eating a heavy meal and/or exposure to heat either just prior to, during, or immediately following inhaling of the vapors. Alcohol is of special importance as found by others[7,8] including Willcutts[4] who found that of 20 men exposed for three to four hours, only those three who had consumed considerable quantities of liquor prior to exposure, became poisoned. Similarly, in our cases, the three men who were hospitalized had consumed considerable liquor over

TABLE 1.—*Laboratory Findings*
Case 2. C.T.M. Admitted 7-13-43. Discharged 9-11-43.

Date	*Urine Albumin*	*Urine Sediment*	*Red Blood Count*	*White Blood Count*	*Differential*	*Icterus Index*	*Blood Urea Nitrogen*	*Blood Nonprotein Nitrogen*	*Other Findings*
7-14	2 +	Granular casts 5 r.b.c. PHPF*	4,330,000	8,150	Pmn. 79 Lym. 21				Kahn negative
7-20									Spinal fluid negative G.I. series negative Chest x-ray normal
7-22	3 +	Gran. and waxy casts 25-30 r.b.c. PHPF	4,370,000	7,770	Pmn. 72 Lym. 18	17.	127 mg. per 100 c.c.	208 mg. per 100 c.c.	Cholesterol, 182 mg./100 c.c. Sodium chloride, 445 mg./100 c.c.
7-27	Trace	Hyaline casts 6-8 w.b.c. PHPF					126	180	
8-4	Trace	Countless r.b.c. 10-15 w.b.c. PHPF							Urine sugar 1 +; concentration and dilution test: fixation of specific gravity - 1010 - 1015
8-9	Negative	No casts No red blood cells					23	46	
8-17	Negative	Occasional cast No r.b.c.	3,390,000	7,450	Pmn. 58 Lym. 42	7.3	12	32	X-ray of chest—no change E.C.G. normal
9-1	Negative	Negative							

* Per high power field.

TABLE 2.—*Laboratory Findings*
Case 3. P.B.H. Admitted 7-12-43. Died 7-23-43.

Date	*Urine Albumin*	*Urine Sediment*	*Red Blood Count*	*White Blood Count*	*Differential*	*Icterus Index*	*Blood Urea. Nitrogen*	*Blood Nonprotein Nitrogen*	*Other Findings*
7-12	Negative	Negative	5,130,000	4,800	Pmn. 63 Lym. 37				Kahn negative
7-13			4,950,000	9,400	Pmn. 84 Lym. 16				Sedimentation rate 4
7-14				11,600					Malaria negative
7-15						25			
7-16				7,200	Pmn. 88 Lym. 12				Sedimentation rate 1
7-19						19			
7-21							142 mg. per 100 c.c.		Cholesterol 147 mg. per 100 c.c. van den Bergh biphasic direct reaction
7-22	2 +	Occasional r.b.c.						135 mg. per 100 c.c.	CO_2 combining power 45 volume per cent
7-23	3 +	Few Casts							

a weekend before being exposed. Possibly this augmentation of the toxic effects of carbon tetrachloride by alcohol is the result of a combined deleterious effect of both drugs upon the liver. Easton,[6] in a recent review, states that carbon tetrachloride has two toxic effects—an immediate narcosis (similar to that following chloroform anesthesia) which follows exposure to heavy concentrations of the vapor for short periods and a secondary toxic effect characterized by acute hepatitis, acute nephritis, and a gastro-enteritis. Narcosis is not necessarily followed by secondary toxicity and, conversely, the latent toxic syndrome may appear without any immediate narcotic symptoms. Similarly McNally[5] reports that, in experimental poisoning of dogs, there is found a narcotic effect, a toxic necrosis of the liver, renal injury, hypoglycemia, depletion of blood calcium and an enteritis. Fats and alcohol increased the toxic effects of the carbon tetrachloride. In human beings, McNally has summarized the symptoms and physical findings as follows: "Nausea, vomiting, abdominal pain, diarrhea, fever and headache appear within twenty-four hours after exposure to the volatilized liquid. Liver tenderness, icterus, hematemesis, hematuria, albuminuria, gradual rise in blood pressure, anuria and cardiac decompensation appear in a few days to several weeks. Transient hiccoughing, subconjunctival hemorrhages, nose bleeds and paroxysmal coughing are reported in a few cases."

From the experimental and clinical material it is apparent that carbon tetrachloride is especially toxic to the liver so that the simultaneous use of alcohol, which is also toxic to the liver, will lead to more serious liver damage. Furthermore, from a perusal of the clinical findings listed above, it is obvious that those having nephritis, diabetes mellitus, myocardial degeneration, high blood pressure, and those known to be heavy drinkers should not be permitted to work with carbon tetrachloride.

SUMMARY OF CASE REPORTS

Three men drank heavily over a weekend and reported for duty Monday morning with "hangovers." They worked from 8:30 A.M. to 11:30 A.M. in a poorly ventilated compartment measuring ten by eleven by fifty feet in size. Three other men, who had not been drinking liquor recently, were also working in the same compartment. The men were cleaning machinery with rags soaked in carbon tetrachloride. They had volatilized approximately one and one-half quarts of the liquid in three hours when they noticed that the smell of the vapor became quite heavy. Only one of the men developed symptoms during the period of exposure. The fatal case (case 3) first felt sick at 10:00 A.M. (one and one-half hours after beginning of exposure) but continued to work until 11:30 A.M. The second victim (case 2) felt well until 6:30 P.M. that evening. The third man (case 1) had left the compartment frequently and had been exposed much less than the first two. He showed no symptoms of poisoning until the following morning. The three non-alcoholic workers developed no symptoms and continued at their duty. The three cases may well be classified into three groups according to severity of the clinical symptoms:

REPORT OF CASES

Case 1.—*Moderate Toxicity:*

This patient had left the compartment frequently and had been exposed much less than the first two. However, he had similar complaints on admission as the other two cases; namely nausea, vomiting, malaise, and epigastric pain. This man improved rapidly and returned to duty in two days. His clinical course was so indefinite that because of a concurrent head cold he was diagnosed as a case of catarrhal fever. The correct diagnosis, however, became apparent when the other two cases were studied and questioned.

Case 2.—*Marked Toxicity with Recovery:*

This patient, a white man 35 years of age, was admitted with symptoms of nausea and vomiting, headache and pain in the upper abdomen. The onset was about 6:30 P.M. on the day of exposure to the carbon tetrachloride. However, the patient was at first not questioned regarding such exposure and since he himself did not realize the danger, he did not volunteer any information. Because of a history suggestive of ulcer, he was diagnosed on admission as possible duodenal ulcer. He stated that he was a steady drinker and that during the past six months he drank from one half to one pint of whiskey whenever he went ashore. This fact in his history was confirmed by contacting his executive officer, and a further admission diagnosis of cirrhosis of the liver was made. The physical findings, on admission, were surprisingly negative. His temperature was 99 degrees, pulse 84, respiration 20 and blood pressure 130 systolic and 70 diastolic. However, his first urine showed two plus albumin, granular casts and a few red blood cells in the sediment. Table I shows how definitely the picture became one of acute nephritis with azotemia. At one time, the urea nitrogen rose to 180 mg. per 100 c.c. of blood and the urine dilution-concentration test showed a fixation of the specific gravity between 1.010 and 1.015. The icterus index rose to 17 but never higher, and the patient did not exhibit visible jaundice. Therapy, in this case, consisted mainly of intravenous injections of large amounts of glucose in saline. About one month after admission, the patient had no complaints, was working around the wards and while the urine showed an occasional cast, his urea nitrogen was 12 mg. per 100 c.c. of blood and his non-protein nitrogen was 32 mg. per 100 c.c. of blood. He was discharged about two months after admission as completely cured with a final diagnosis of carbon tetrachloride poisoning.

Case 3.—*Marked Toxicity with Fatal Termination:*

This patient, a white man 28 years of age, was exposed to carbon tetrachloride vapors at 8:30 A.M. on July 11, 1943. He began to feel ill at 10 A.M. when he complained of vague malaise and dull epigastric pain. He had a bloated feeling, became nauseated and, after eating his noon meal, began to vomit. Shortly thereafter, he developed diarrhea with watery stools about every hour. On July 12, 1943, he was admitted to the hospital. Because he had a suggestive clinical picture, an electrocardiograph was made. This showed inverted T waves in leads II and IV. At this time his temperature was 99, pulse 100, respirations 20 and blood pressure 138/72. A provisional diagnosis of "coronary occlusion" was made, but in the next two days, the sedimentation rate was found to be normal. No leukocytosis was found and the electrocardiograph became normal, so that the diagnosis of coronary occlusion was considered unlikely. On July 14, 1943, he developed persistent nausea and vomiting. The vomitus was usually bile stained and, at times, streaked with blood. On July 16, 1943, subconjunctival hemorrhages appeared. X-ray examination, at this time, showed an enlargement of the heart shadow and some evidence of congestion in both lung fields, particularly the right base. On July 21, he showed edema of the lower extremities, a partial anuria, marked restlessness and a rapid pulse. The blood pressure rose to 170/96. Symptoms of uremia rapidly appeared and the laboratory findings (Table II) showed marked retention of non-protein nitrogenous substances and acidosis.

In this case, as in the preceding case, there was an elevation of the icterus index, which, in the presence of a normal fragility test, a biphasic direct van den Bergh and a fairly normal red blood cell count was interpreted as resulting from a hepatitis. On July 23, 1943, the patient expired rather suddenly, eleven days after admission.

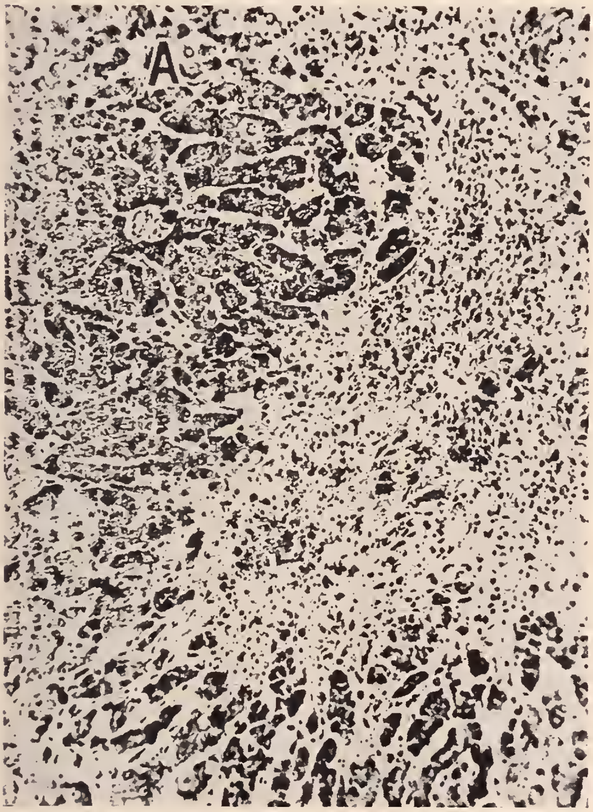

Fig. 1.—Case 3. Toxic necrosis of liver. Note central vein in upper right (A) with mid-zonal and peripheral necrosis below.

Necropsy Findings:

A summary of the necropsy findings showed the following: There was a moderate pulmonary edema. The left lung weighed 620 grams; the right lung weighed 950 grams. Both lungs showed pitting on pressure and considerable fluid oozed from the cut surfaces. The heart weighed 465 grams and was dilated so that the right border was 9.5 cm. from the midline and the left border was 11 cm. from the midline. The coronaries

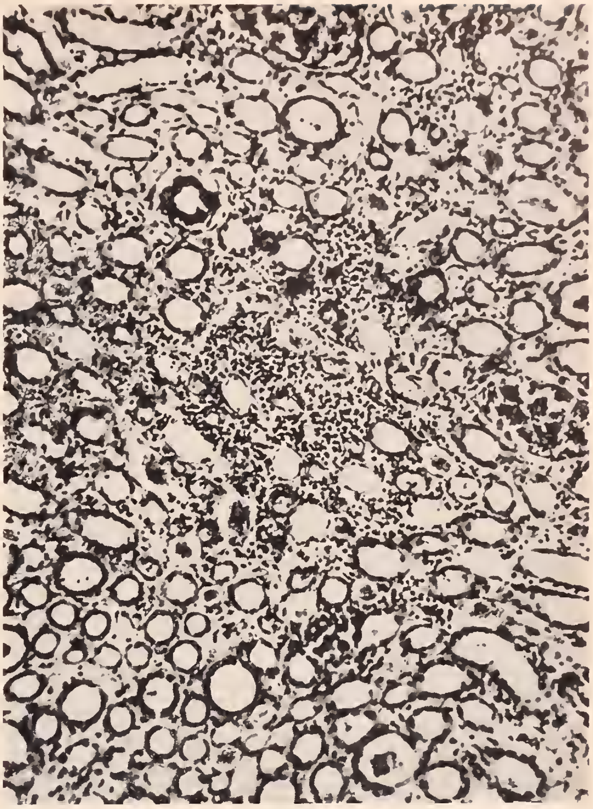

Fig. 2.—Case 3. Kidney—low power, showing interstitial collections of inflammatory cells including monocytes and frequent eosinophiles (most prominent in central section of photomicrograph).

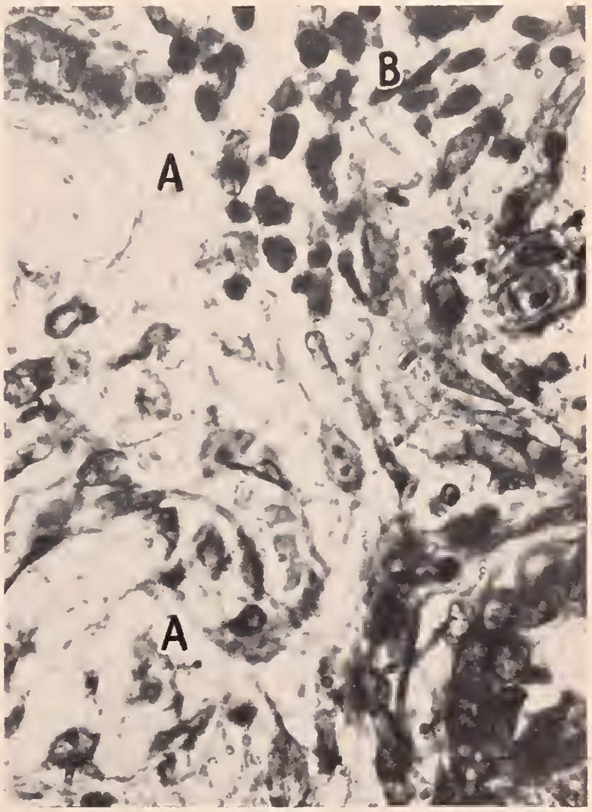

Fig. 3.—Case 3. Kidney—high power, showing interstitial edema above (at A) and inflammatory cells in interstitial tissue to right (at B).

showed no significant atherosclerosis and there was no occlusion. The liver was enlarged and weighed 1900 grams. The cut surface showed a yellow mottling. The spleen was enlarged, weighing 240 grams. Both kidneys were enlarged, each weighing 350 grams. The appearance was that of a large white kidney, and fluid oozed freely from the cut surfaces. The remaining viscera showed no significant changes from normal. The anatomic diagnoses were:

1. Acute Nephritis.
2. Pulmonary edema.
3. Cardiac dilatation.
4. Cardiac hypertrophy.
5. Hepatomegaly with toxic necrosis.
6. Splenomegaly.

COMMENT

Microscopic studies of the liver and kidney were especially interesting. Sections of the liver (Fig. 1) showed extensive focal necrosis, mainly peripheral, sometimes central. The hepatic cells in the center of such areas showed actual necrosis while the adjacent cells showed fatty and granular degenerative changes. The sinusoids were also involved with resultant leakage of red blood cells into such areas. Pigment-filled reticulo-endothelial cells were prominent. Sections of kidney (Fig. 2) showed many interstitial collections of mononuclear cells and eosinophiles. Occasional tubules contained casts. There was also present an interstitial edema and, in areas, there was interstitial hemorrhage (Fig. 3). The convoluted tubules showed considerable granular degeneration but the glomeruli did not show findings of acute glomerulitis. The microscopic findings in the kidney corresponded to what is seen in acute interstitial nephritis as described by Karsner[9] and as seen in so-called hepatorenal syndrome and called toxic nephrosis by Smetana[10] and by Corcoran et al.[11] The latter workers made a study of the functional changes in toxic nephrosis due to carbon tetrachloride and showed that complete recovery with normal renal function may occur. The findings in the kidney indicate that carbon tetrachloride should be considered a renal poison equivalent, in importance, to mercury.

Since we do not know definitely whether there will be any sequelae to an acute poisoning, patients once exposed and developing symptoms should not be permitted to work where they may again be exposed to carbon tetrachloride vapors. Prevention may be accomplished by education of the men as to the dangers involved, by proper ventilation, by use of masks, by rotation of jobs and, finally, by careful examination of the men. The possibility of chronic poisoning from small repeated exposures should be kept in mind

SUMMARY

The dangers of exposure to carbon tetrachloride are presented. Carbon tetrachloride is a potent renal poison, resulting, in severe cases, in acute toxic nephrosis with uremia. Hepatitis is also found but is not marked. Alcohol ingestion prior to exposure plays a synergistic rôle. Three cases, illustrating three grades of severity of intoxication from carbon tetrachloride, are presented. The necropsy findings of the fatal case are described and discussed.

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MEDICAL EPONYM

Weil-Felix Reaction

A paper entitled "Zur serologischen Diagnose des Fleckfiebers [Serologic Diagnosis of Typhus Fever]," by E. Weil (1880-1922) and A. Felix (b. 1887), appeared in *Wiener klinische Wochenschrift* (29:33-35, 1916). A portion of the translation follows:

"During the latter part of September, 1915, we had an opportunity to study bacteriologically, serologically and, in part, clinically, a group of cases of typhus fever in the town of R., in East Galicia. . . . Because of the coincident prevalence of typhoid fever, we were in doubt concerning the diagnosis in the first of our cases. . . . Nevertheless we were struck by the fact that no typhoid bacilli could be recovered from any of the first nine cases observed. . . . On the other hand, we cultivated a microörganism from the urine of patient V. . . . that was not agglutinated by typhoid, paratyphoid, A and B, or dysentery antiserums, but which did show agglutination with the patient's own serum in a 1:200 dilution. . . . Thirty-three cases observed in R. had been diagnosed as typhus fever. . . . All thirty-three serums gave an agglutination reaction with the bacillus under cultivation. . . . The specific agglutinins appeared at an early stage of the illness. They had reached their maximum at the time of appearance of the exanthem, persisted at this level during the febrile period of approximately fourteen days and quickly disappeared after defervescence. . . .

"We do not feel justified in regarding this germ as the provocative agent of typhus fever. . . . Nevertheless we apparently have in this microörganism a means of assistance in the diagnosis of typhus fever."

The organism is further described as a "short, delicate Gram-negative rod, resembling proteus, and weakly motile."—R. W B., in *New England Journal of Medicine.*

PUBLIC HEALTH: A MEDICAL SPECIALTY*

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How Physicians Established State Public Health Activities in California.—The call for the organization of the California Medical Association was issued by Dr. Thomas M. Logan, of Sacramento, and Dr. E. S. Cooper, of San Francisco in 1856. Dr. Logan had come to Sacramento in 1850 from New Orleans, where he had been on the staff of the Charity Hospital. He was a native of South Carolina, where he practiced medicine for many years. Like many other practitioners from the Southern States, he was attracted to California by the Gold Rush, not that he desired to accumulate wealth, but with a spirit of adventure which prevailed among young doctors of that day.

Dr. Cooper, for whom the Cooper Medical School was named, was a native of Peoria, Illinois, who came to San Francisco in the early fifties. The fame of his skill as a surgeon spread far and wide shortly after his arrival in California. He and Dr. Logan became impressed with the fact that many of the diseases, commonly encountered in their practice in other states, assumed new forms and characteristics in California. Early-day practitioners of medicine had no way of passing on the information they had gathered through observation of patients in their respective practices. There was no vehicle by which the information so collected might be transmitted to colleagues for their common good. It was for this reason that they decided upon the organization of the California Medical Association.

MEDICAL SOCIETY OF THE STATE OF CALIFORNIA—ITS FOUNDING

At the first meeting held in Pioneer Hall, Sacramento, in April, 1856, more than 100 practitioners of medicine were in attendance—a considerably larger group than attended the organization meeting of the American Medical Association which was held only a few months before.

Dr. Logan was intensely interested in public health, although at that time public health was unorganized and unrecognized. When he arrived in California, he brought with him instruments that he had obtained from the Smithsonian Institution in Washington, for measuring temperature, rainfall, humidity, and meteorological phenomena. Medical topography, climatology, and meteorology were at that time considered closely related to the health of people. He sent questionnaires to all of the practitioners in the State whose names he could gather, asking them to report upon the prevalence of communicable diseases, the characteristics of the prevailing weather, soil conditions, presence of standing water, and other factors that he thought might have a bearing upon incidence of communicable diseases. The reports that he prepared from these questionnaires formed the basis of many articles that he contributed to the early medical journals.

The newly-formed Medical Society of the State of California became inactive just before 1860, and for ten years it existed only on paper. In 1870 Dr. Logan reorganized the Society and it has functioned continuously ever since. He was elected president of the organization in 1870 and served in that capacity for several years. In 1873 he was elected President of the American Medical Association, which organization he also served creditably and faithfully.

CALIFORNIA STATE BOARD OF PUBLIC HEALTH—SECOND TO BE ESTABLISHED IN THE UNITED STATES

In the 'Sixties, when there was no active state medical organization, Dr. Logan had devoted his energy toward the organization of a State Board of Health. He belonged to many scientific organizations on the Atlantic Seaboard, and was in close touch with the development of a state public health organization that started in Massachusetts in the early 'Fifties. It was not until the Fall of 1869, however, that Massachusetts was able to establish a State Board of Health in its state government.

Almost single-handed, Dr. Logan put a bill through the California Legislature to establish the California State Board of Health, which was organized April 15, 1870, (coincidentally with the reorganization of the California Medical Association) whose first secretary and executive officer he became.

Since the California legislature worked under the biennial session plan, it was not possible for Doctor Logan in the year 1869 to secure the enactment of his law designed to create the establishment of the California State Department of Public Health. The honor of having the first State Department of Public Health therefore goes to Massachusetts, for the year 1869, California being second, in the year 1870.

The first President of the California State Board of Health was Dr. Henry Gibbons, who had come to California from Delaware and was the grandfather of our honored Dr. Morton Gibbons, now rendering a splendid service in Medical Defense.

There is great significance in the fact that practitioners of medicine in California were responsible for the creation of the California State Board of Health, and that the medical profession in the State has guided this organization from the beginning.

FIRST REPORT BY DR. LOGAN

The first report of the Board, prepared by Dr. Logan, covers many problems that are of primary importance today. Among them, may be mentioned the control of tuberculosis, malaria, venereal diseases, as well as the common diseases of children, vaccination against small pox, sewage disposal, vital statistics, and proper disposal of human remains. Dr. Logan served as Secretary of the State Board of Health until his untimely death, in February, 1876. His passing was largely due to overwork, through his efforts to put teeth into the inadequate public health laws of the time.

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* Chairman's Address. Read before the Section on Public Health, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

In his first report to the Governor, Dr. Logan said:

> "We rejoice, as citizens, that the advanced intelligence of the people, through their legislative representatives, has recognized the principle above all others by which society subsists, of the sacredness of human life, which cannot be impaired or wasted by neglect, any more than it can rightfully be taken by violence; and we rejoice still more, as members of a philanthropic profession, that a needful provision has now been made, through the established channels which the progressive experience and the constantly increasing demands of civilization both require and render practicable, for securing the lives, the health, and the social protection of the people, in accordance with the well-defined truths of hygienic science, as related to civil government. . . .
>
> "For the prosecution, therefore, of the work before us, there can be no arrogance in claiming that none are better prepared than physicians, inasmuch as their preparation lies in the possession of the knowledge essentially necessary to the proper performance of their professional duties; and that knowledge tells us, in no doubtful terms, that the fate of man is in his own hands."

These prophetic words, spoken almost 75 years ago, are as true today as they were at that time. The transcontinental railroad had been completed only a year before—mail having been carried across the continent only by Pony Express and Stage Coach, or by water, or across the Isthmus of Panama. California existed in a state of isolated grandeur. It was these foresighted men, associated with Dr. Logan, who envisioned the development of California, and who laid the foundations for the promotion and maintenance of the health of the people who were to follow.

Referring to one other activity of Doctor Thomas M. Logan, it may be of interest to mention an article in California and Western Medicine (January, 1940) pages 2 and 6, in which attention is called to a proposed law presented to the 42nd Congress on December 13, 1872, advocating a Secretary of Public Health who would be a member of the cabinet of the President of the United States. A number of European nations give such a proper place to public health activities. It will be of interest to note how many more years must elapse before similar recognition is given to such expression of social welfare work in the United States.

PART-TIME HEALTH OFFICERS

With the growth of the metropolitan areas, it became apparent to everyone that community health facilities must be established and developed. The first step was the appointment of part-time health officers, many of whom were busy practitioners of medecine; some chosen because of their regard for and knowledge of community health problems, others because of influence with governing bodies. In this stage yet stands the health service in many of the less populous cities and counties of the State.

FULL-TIME HEALTH OFFICERS

As time went on, however, the larger cities, realizing that few men can give effective service on a part-time basis, more and more demanded the full-time service of the health officer in charge. In 1915, Los Angeles County established a department under the leadership of Dr. John L. Pomeroy, who served in this capacity continuously until his death in 1941, and who, in this period of time, organized one of the most progressive and effective public health units in this country.

At present, 28 counties and 10 cities have so come to recognize the value of this type of health organization that more than 85 per cent of the population of the State is served by health officers who devote their entire time, or the major portion, to the community rather than to the individual patient.

Let me pause here to pay more than passing tribute to the fine record of a large number of part-time health officers. I refer to those physicians who, even in this period of extreme pressure, devote great interest and energy in the maintenance of community health. Many of these men have been giving, through the years and in the present crisis, service far in excess of the honoraria they have received from the governing bodies of their respective cities and counties. Through their efforts, health services have been, and are being developed in the less populous sections of the State.

CALIFORNIA ESTABLISHES A SCHOOL OF PUBLIC HEALTH AT U. C.

One of the great needs of California and of the West has been for a school of public health where doctors, nurses, sanitarians, and other technical personnel might be trained in the techniques of community health.

Only recently, public health was officially recognized as a medical specialty by the American Medical Association.

Culminating years of effort on the part of public health organizations of the State, the legislature of 1943 enacted legislation establishing a school of public health in the University of California. On March 1 of this year the Board of Regents of the University established the school, and within the next few weeks it is expected that the academic Senate will effect the initial organization.

This school will provide the facilities so greatly needed for the training of personnel, and will be a forward step in the professionalization of the Public Health services in the West.

Since the establishment of the first school of Public Health at Johns Hopkins in 1918, training facilities have gradually increased until there are now thirteen centers at which this special training is available.

C. M. A. SECTION ON PUBLIC HEALTH

Whatever have been the factors and forces which have, until this time, prevented the establishment of a section on Public Health in the California Medical Association, it is now a fact accomplished—its future rests squarely on our shoulders. It may take some time before Health Officers will develop the habit of attending the annual meeting of the Association.

At present, and for many years, the Health Officers' Association of our State has met with the public health department of the League of California Cities. This coöperation will continue because of the close relationship with the governing bodies of the cities of the State.

HEALTH OFFICERS AND ORGANIZED MEDICINE

A fairly large number of health officers are not members of the California Medical Association, and for this again there are reasons. In some instances, health officers have not felt welcome at the State Association meetings, and in others the health officer has held himself aloof from the Association. In most cases, however, the successful health officer and his associates are active members and integral parts of the Association. If this public health section is to be a success, this relationship must be fostered and developed both by the California Medical Association and the Public Health associations. Every health officer should be an active member of his respective county medical association.

The public health section can do a great deal to enhance the mutual value of the private practitioner of medicine and the public health practitioner. This is emphasized when one stops to realize that, while the department of public health has the immediate responsibility for the control of disease, the most important force in this control is the private practitioner of medicine.

IN CONCLUSION

As chairman, at this first meeting of the newly-established Section on Public Health, I know I may express the appreciation of our group for the action that led the C.M.A. chairman of the Committee on Scientific Work, Dr. George H. Kress, to secure the approval and consent of the Council of the California Medical Association to establish this additional scientific section. The excellent attendance at this initial session is most gratifying and bespeaks increasing interest for the sessions to be held in years still ahead.

703 California State Building.

Rudolf Virchow (1821-1902).—In the history of pathology there is no more dominant figure than that of Rudolf Virchow. His book, "Cellular-Pathologie," established the doctrine of cellular pathology, and marked a new high in the advance of modern scientific medicine. Military sanitation was another field in which Virchow did outstanding work. However, although he was intensely interested in the medical aspects of war, he deplored the fact that wars should be necessary. His writings on the subject show that he labored valiantly in the cause of lasting and universal peace.—Warner's *Calendar of Medical History.*

LEUKEMIA AS A CAUSE OF NASAL OBSTRUCTION

REPORT OF CASE

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CASES of leukemia in which infiltration or tumor masses have localized in the nasal passages and progressed to cause obstructive symptoms are apparently very rare. In 1925, Seelenfreund[1] reviewed the literature of leukemic changes in all parts of the upper respiratory tract and found that forty cases has been reported since 1845. Those few reports that concerned changes in the nasal mucosa described a pale lesion with intact epithelium beneath which a leukemic stroma infiltrated about and into blood vessels and ducts, replacing the normal connective tissue. "The infiltrations for the most part lie quite flat, so that there is no great hindrance even though the mucosa thickens. . . . There is also no case known in which such an infiltration has led to a surgical procedure in order to make the air supply better." Suchannek,[2] in 1890, reported a case of lymphatic leukemia in which leukemic tissue infiltrated the nasal mucosa both diffusely and in circumscribed lymphomatous nodules. There was no obstruction. Sternberg[3] described, in 1921, a case of lymphatic leukemia with the most marked symptoms and signs in the tonsils; however, the nasal, laryngeal, and tracheal mucosae were also affected, presenting everywhere a pale appearance and showing some areas to be thickened by a typical infiltrative process. Menzel,[4] in 1924 reviewed one case that he had reported in 1904 and presented a new case. Both of his patients suffered from lymphatic leukemia, and both developed extensive involvement of the paranasal sinuses as well as moderate infiltration of the nasal mucosa. The nasal lesions were diffuse and smooth with intact epithelium; the mucosa and submucosa were replaced by a leukemic stroma which was most intense in the superficial layers, but extended down to the basic supportive cartilaginous or muscle tissues. Both Menzel and Sternberg urged more earnest postmortem search for upper respiratory lesions. Menzel remarked that both of his cases were of the lymphogenous form of leukemia, wondering if further observations would discover nasal and paranasal lesions of other leukemic types. In 1936, Love[5] reviewed a series of forty-one cases of leukemia with oral or otorhinoloryngeal manifestations. He stated that two patients presented leukemic infiltration of the skin and mucous membrane of the nose, but he described only one. The patient had a lymphogenous leukemia with profuse nasal discharge and complete obstruction of both nasal passages for several weeks. A biopsy of the mucosa overlying a lower turbinate showed an area of necrosis extending into the submucosa where in some areas there was a marked infiltration of immature mononuclear cells and eosinophils. It is not clear if the nasal obstruction were dependent solely upon mucosal thickening by leukemic infiltration or more upon the swelling of edema and

TABLE 1.—*Summary of Blood Studies*

Dates	(Millions) Red Cells	(Sahli) Hgb	White Cells	Monocytes % Immature	% Pmm	Other
9-18-40	3.23	56	28,800	96.7	0.3	4% lymphocytes
9-23-40	3.50	71	13,750	87	0	13% lymphocytes
9-25-40		68	18,700	90.5	0.5	
9-28-40			30,150	88	0	12% lymphocytes
9-30-40		68	25,600	90	0.5	
10- 2-40			58,500	93	0	7% lymphocytes
10- 4-40		68	64,150	94	0	
10- 5-40		68	70,950	96	0	4% lymphocytes
10- 7-40		68	99,300	96	0	
10- 8-40		68	101,850	95	0	
10- 9-40		68	100,700	96	0	
10-10-40		65	100,300	96	0	(Transfusion)
10-11-40		80	98,300	95	0	
10-12-40						(x-ray bath)
10-14-40		74	83,850	96	0	
10-15-40		74	54,300	95	0	
10-16-40		74	51,350	96	0	
10-17-40		74	67,150	95.8	0.2	4% lymphocytes
10-18-40		74	58,100	95.8	0.2	4% lymphocytes
10-19-40		74	62,900	96	0.2	(x-ray bath)
10-21-40		74	26,550	96	0	
10-22-40		74	26,300	86	0.5	13.5 % lymphocytes
10-23-40		71	31,925			
10-24-40		71	26,900	90	0.5	
10-25-40		68	32,950	89	0	11% lymphocytes
10-26-40		68	35,200	91	0.5	
10-28-40		68	34,900	91	0	(x-ray bath)
10-29-40		65	24,550	93	1.0	
10-30-40		62	31,700	93	0.5	
10-31-40		57	43,250	94	1.0	
11- 1-40		52	17,100	88	4.0	(Transfusion)
11- 4-40		56	18,500	91	4.0	
11- 5-40		62	13,450	94	3.0	
11- 6-40			13,900	93	1.0	
11- 7-40		59	11,500	93	0	
11- 8-40	3.13	59	9,500	92	1.0	7% lymphocytes
11- 9-40		62	10,200	92.5	0.5	
11-11-40			14,050	89.5	0.5	
11-12-40		65	12,000	91.5	0.5	platelets 28,000
11-13-40	3.63	65	15,600	93.5	0.5	(Transfusion)
11-14-40	3.38	62	12,450	90	0	1% myelocytes
11-16-40		77	20,700	94.5	0.5	
11-18-40	3.42	68	21,000	88	0	1% myelocytes
11-22-40	3.78	74	40,000	92.5	0.5	
11-25-40	2.86	56	17,600	77	20.0	3% lymphocytes
11-26-40	2.90	56	17,400	60	28.0	7% lymphocytes 2% metamyelocytes 3% myelocytes 12% banded pmn's

congestion related to a superimposed secondary infection. In his excellent monograph, Forkner[6] refers to the leukemic changes of the upper respiratory tract and mouth as being of two groups: the nonspecific leukemids and the specific infiltrations. Regarding the latter, he emphasizes the intensity of the infiltration particularly about the blood vessels, and states that many such lesions have been reported as occurring in the larynx and trachea. Fewer reports concern the nose and sinuses, though Forkner recalls that Viedebeck, Jaffé, and others have pointed out that localized leukemic lesions in the upper respiratory tract may constitute the first and most striking manifestations of the disease. This is well illustrated in the report of Haffly and Schipfer,[7] whose patient's presenting complaints were "pronounced bilateral nasal obstruction, progressively becoming more severe during the preceding twelve months, and a distressing sore throat of three weeks' duration." On examination it was found that "both nares were blocked by a large, bluish-gray, irregularly shaped tumor" which bled easily; by x-ray the right ethmoid cells were seen to be completely clouded and obscured by a tumefaction. Two x-ray treatments given locally over the nasal tumor resulted in its complete disappearance. Hematologic studies indicated a predominance of monoblasts, though it is stated that at autopsy all of the organs were infiltrated by a lymphoblastic type of cell. A cervical lymph node taken at biopsy was infiltrated with "a uniform, darkly staining mononuclear cell containing many mitotic figures." Classification of the case seems uncertain.

REPORT OF CASE

History.—Mrs. E. M., a 61-year-old white, American woman, was admitted to the Palo Alto Hospital on September 17, 1940, a patient of Dr. Ralph D. Howe, with whom I saw her in consultation. Her chief complaint was chest pain. The present illness had started five weeks before entry, when she had suffered with a severe sore throat that persisted seven to ten days. After two weeks of freedom from symptoms the sore throat recurred; it was associated with pain in the left side of the chest posteriorly, and with a dull ache in the left upper quadrant of the abdomen. The past medical and family history were non-contributory.

Physical Examination.—Oral temperature, 102. The patient was in moderate distress and mildly cachectic. Her eyes, ears, and nose showed no abnormalities. The gums were of normal appearance. There was moderate redness of the posterior pharyngeal wall. No lymph nodes were palpable in the cervical region or elsewhere. Respirations were shallow and moderately rapid, and there was some splinting of the left side of the chest. Below the fifth rib, posteriorly, on the left side, there was percussion dullness; crepitant râles and a pleural friction rub could be heard in this area. The heart was not enlarged, rhythm was regular, and there was no murmur. There was guarding and tenderness in the left upper quadrant, but the spleen was not palpable. The rest of the physical examination was without positive finding.

Laboratory.—The urine examination was negative except for a trace of albumin. Complete blood count on September 18, 1940 showed: hemoglobin, 56 per cent (Sahli); red blood cells, 3,230,000; white blood cells, 28,800, of which 96.7 per cent were large, immature monocytic cells, 3 per cent were lymphocytes, and 0.3 per cent were polymorphonuclears.

Diagnosis.—Leukemia, acute, type uncertain.

Laboratory Course.—Between September 18, 1940, and November 22, 1940, forty-seven blood counts were made (see Table 1). The total white count ranged from 9,500 to 101,850. The differential counts revealed a predominance of large, immature, monocytic cells that had a furrowed or folded nucleus containing moderately fine chromatin structure and nucleoli; the cytoplasm was pale, finely granular, and in most instances contained fine, azurophilic granules. The hematologist, Dr. H. A. Wyckoff of the Stanford University School of Medicine, regarded these cells as monoblasts. At every examination during this period these immature cells composed from 88 to 96 per cent of the total white cell count. On the last two days of the patient's illness the total white cell count was between 17,000 and 18,000, and the differential counts revealed a decrease in the percentage of immature monocytic cells to sixty with an increase in metamyelocytes to 2 per cent, of myelocytes to 3 per cent, of banded polymorphonuclears to 12 per cent, and mature polymorphonuclears to 16 per cent. Previously the cells of the polymorphonuclear series had never exceeded 4 per cent, and usually composed less than one per cent of the total white cells. Blood platelets were counted twice and found to be between 28,000 and 30,000. The hemoglobin varied from 46 to 77 per cent (Sahli).

Therapy.—Four transfusions of citrated blood, 500 cubic centimeters each, were given during the three months of illness. These had no noticeable effect. A "general x-ray body bath" was given upon three occasions. Following each of these there was a marked decrease in the total number of white cells, but no alteration of the differential count.

Clinical Course.—The illness was one of steadily increasing weakness and decline ending with high fever, signs of generalized bronchopneumonia and death on November 26, 1940. On October 13, 1940, the spleen was easily palpated just below the left coastal margin. On October 21, 1940, the patient first noted a slight degree of obstruction in the left nostril. At this time two small lymph nodes became palpable in the posterior cervical chain, and there were other small nodes felt in the axillary and inguinal regions. Because the nasal symptoms slowly progressed to those of complete obstruction, Dr. R. Wesley Wright was called in for rhinologic consultation. The note of his examination made on November 11, 1940, is as follows: "On the left side of her nose there are two pale, irregular growths or infiltrations—one from the septum, starting almost immediately back of the vestibule; and the other from the inferior turbinate. This closes the space entirely, so that there is almost no line of cleavage between these two structures to be found there. Nothing can be inserted back farther, and there is absolutely no breathing space. . . . The right side shows a very slight beginning of pale corrugations on the septum and also on the inferior turbinate, but this side is still patent." The throat showed some slight submucosal hemorrhages around the anterior pillar on the left side where there were several small ulcerated areas. In the upper part of the pharynx there was also a small patch of early infiltration. X-ray therapy was given locally to the nasal infiltration (two treatments, five days apart), but was without effect on the appearance of the lesions or on the obstructive symptoms. The patient's general condition and her bleeding time, which was increased to ten minutes, seemed definite contraindications to any surgical procedure. On October 30, 1940, the patient developed a severe attack of herpes zoster with lesions in the distribution of the cervical nerves two and three on the left side. Several of the lesions became necrotic, and one created an ulcer about 3 by 4 centimeters in diameter on the back of the neck. Her death on November 26, 1940, came three and one-half months after the onset of her first symptoms.

Autopsy.—Postmortem studies were performed by Dr. Burt L. Davis. Permission for extensive examination of the head was not granted, but specimens of the nasal infiltration were obtained. The left lung at the base showed broad areas of brawny infiltration or tumor approximately two centimeters thick and covering most of the left lower lobe. The spleen was twice its normal size. Pyer's patches were prominent in the small intestine. Vertebral marrow was dark red. Other organs showed no gross abnormalities.

Histologic Examination:

Turbinate.—"Some of the sections show fragments of normal epithelium, but most sections show the mucosa infiltrated with irregular cells which have nuclei of various sizes and shapes, and pale staining cytoplasm. This extends downward between the mucous glands as deeply as the cartilage. Throughout the mass there are large numbers of polymorphonuclear leukocytes."

Lung.—"A section from the left base shows marked destruction of the usual pulmonary tissue. . . . Scattered through this material are numbers of large mononuclear cells which have fairly abundant basophilic cytoplasm and round to oval and, in many instances, kidney-shaped, pale-staining trabeculated nuclei; many show nucleoli, and numerous chromatin bars are seen." All other organs showed more or less infiltration with these mononuclear cells, and they were the predominant cell of the bone marrow.

COMMENT

This case is of interest for several reasons. The review of the literature shows clearly that nasal obstruction on the basis of leukemic infiltration of the mucosa is rarely encountered. Only the case reported by Haffly and Schipfer appears directly comparable with ours, and it is perhaps worth noting that both cases were granted hematologic diagnoses of monocytic leukemia. Despite the failure of local x-ray therapy to alter the nasal lesions of our patient, it would seem still to be the treatment of choice: surgical intervention is contraindicated because of the bleeding tendency of leukemic patients, and the experience of Haffly and Schipfer shows that roentgen rays may produce excellent results. A point of minor interest is the occurrence of herpes zoster in the course of the illness. This frequent concomitant of leukemia is said to be caused by infiltration into or about the dorsal roots of the spinal cord. Two features of the case relative to the question of its classification should be remarked: (1) The unusually high and fairly constant percentage of early monocytic forms which was maintained until the last two days of life, regardless of the fluctuation of the total white blood count; and (2) the definite change in the differential white-cell count in those final days to one showing a very appreciable percentage of immature and mature cells of the polymorphonuclear series. Those who do not acknowledge monocytic leukemia to be a distinct entity (Naegli, Piney, Kracke, Garver, and others) would perhaps point to this shift as evidence that the present case truly is one of the myelogenous type; Schilling, Sabin, Clough, and others consider these alterations in the differential count as not incompatible with a diagnosis of monocytic leukemia. Wyckoff[8] has succinctly described two types of blood picture occurring in this disease, with the conclusion that monocytic leukemia can be certainly identified. A final point of interest is that there were no troublesome oral lesions during this patient's illness, a want that is contrary to the usual experience as described by Clough and Forkner.

SUMMARY

A case of monocytic leukemia has been reported in which nasal obstruction due to mucosal infiltrations is described. A review of the literature reveals this to be a rare occurrence. Other features of especial interest in this case are discussed.

Laguna Honda Home.

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Those in the general health field are apprehensive wherever social and economic factors have dislocated and reconcentrated large groups of the population. Such upheavals create what might be called an epidemic potential. One soon knows what is happening in acute communicable diseases for there is a sharp dividing line between health and acute disease. This is not the case in tuberculosis. Here the period of incubation as used in its ordinary sense, is vague, ill-defined, and long-drawn out. The onset is not dramatic and neither morbidity nor mortality figures of today reflect what is happening currently. Insofar as this disease is concerned, the aftermath of the present social and economic dislocations is as important, if not more important than the immediate effect. One must meet current problems as they arise but one must recognize that danger may not manifest itself for years to come.—Harry Mustard, M. D., *Transactions, N. T. A.*, 1943.

George Dock Receives Distinguished Service Award

The Distinguished Service Medal and Award of the American Association for year 1944 were conferred on Dr. George Dock, of Pasadena, Calif., famous physician and medical educator. Dr. Dock was born at Hopewell, Pa., April 1, 1860. He received the M.D. degree from the University of Pennsylvania in 1884, an honorary A.M. from Harvard in 1895, the ScD. from the University of Pennsylvania in 1904 and the LL.D. from the University of Southern California in 1936. From 1887 to 1888 Dr. Dock was assistant clinical professor of pathology at the University of Pennsylvania, becoming professor of pathology at the Texas Medical College and Hospital in 1888. He left Texas in 1891 and became professor of the theory and practice of medicine and clinical medicine at the University of Michigan, where he remained until 1908. From the latter year until 1910 he held the same title at Tulane University Medical School. He was professor of medicine at Washington University School of Medicine, 1910 to 1922, and dean part of that time. He is honorary professor of medicine at the University of Southern California and a member of numerous medical societies, including the American Medical Association, American Association for the Advancement of Science and Association of American Physicians, of which he was president in 1916-17. He is co-author of a book on hookworm disease and of articles and chapters in many textbooks on medicine. A happy conjunction of events led to the celebration of Dr. Dock's eightieth birthday at a dinner at the Los Angeles County Medical Society in April, 1940, on which occasion the organization of the Walter Jarvis Barlow Society of the History of Medicine simultaneously held its first public meeting and the birth of the George Dock Lectureship in the History of Medicine also took place, Dr. Dock being the first lecturer. The award to Dr. Dock of this honor adds a new name to the distinguished list of those who have already been recognized in this manner, including Dr. Rudolph Matas in 1938, Dr. James B. Herrick in 1939, Dr. Chevalier Jackson in 1940, Dr. James Ewing in 1941, Dr. Ludvig Hektoen in 1942 and Dr. Elliott P. Joslin in 1943.—*J.A.M.A.*, June 24, 1944.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

LIAISON COMMITTEE OF SIX

California Medical Association Committee of Three and Association of California Hospitals Committee of Three

Minutes of the First Meeting of the Committee of Six.—The meeting was called to order in the offices of the California Medical Association in San Francisco at 9:00 A.M., on Sunday, June 18, 1944.

Members Present: From the California Medical Association: John W. Cline, M.D., Chairman, San Francisco; L. A. Alesen, M.D., Los Angeles; T. Henshaw Kelly, M.D., San Francisco.

From Association of California Hospitals: Mr. Jesse V. Buck, Chairman, Whittier; Mr. A. E. Maffly, Berkeley.

Present by Invitation: Mr. A. A. Aita, President of Association of California Hospitals; Mr. Thomas F. Clark, Secretary, Association of California Hospitals; and George H. Kress, M.D., Secretary, California Medical Association.

Dr. John W. Cline presided as chairman of this 9:00 o'clock session of the Committee.

* * *

Speaking for the Committee of the California Medical Association, Dr. Cline suggested for consideration some basic principles upon which joint action might be desirable, with particular reference to the institution of a Blue Cross hospitalization set-up in California that would make it possible for a medical service plan such as California Physicians' Service and the hospitalization organizations to move forward in harmonious and efficient manner. The memorandum as submitted by Dr. Cline follows:

Medical and Hospital Service Plans: Basic Principles Upon Which Joint Action Can Be Obtained

(Steps to be First Taken by the Association of California Hospitals, Its Member Hospitals and the Three Hospital Service Plans.)

(1) A single statewide hospital service plan should be formed (either by merger of the existing plans or by creation of a new corporation).

(2) All hospitals to participate in such hospital service plan, both as to voting membership and financially. The financial participation to include at least acceptance of a flat rate for hospitalization, and reduced rates if the plan is unable to pay in full.

Steps to be Taken by Resulting Unified Hospital Service Plan and C.P.S.

A. Such hospital service plan and C.P.S. then to undertake *joint* action as follows:

(1) Uniform contract forms and provisions.

(2) Promotion, public relations and sales.

(3) Office administration, *e.g.*, billing, collecting, claims, statistics, etc.

B. These principles be agreed to in writing by the California Medical Association, the Association of California Hosptals, California Physicians' Service, the Hospital Service of California, the Hospital Service of Southern California, and Intercoast Hospitalization Insurance Association, under authorization of their respective Boards of Directors. (Thereafter, the California Medical Association and Association of California Hospitals Committee of Three should be empowered to act and find ways and means of putting these principles into effect.)

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† For complete roster of officers, see advertising pages 2, 4, and 6.

Dr. Cline stated he was of the opinion that it might also be wise to consider adding the following under A. of the foregoing, as provision (4):

A. (4) Principle of arbitration. The statewide hospitalization plan and C.P.S. agree to submit to arbitration any problems arising out of their relations which cannot be solved by negotiation. Discussion followed.

* * *

Mr. Buck presented, on behalf of the Committee of Three of the Association of California Hospitals, a statement in which was incorporated the action taken by the Board of Trustees of the Association of California Hospitals at a meeting held on the previous day, at which meeting representatives of the hospitalization groups were also present. Mr. Buck stated that the various phases of existing conditions and proposed plans were discussed in considerable detail. Further, that the Board of Trustees of the Association of California Hospitals had given its own Committee of Three the following resolution for its guidance:

That the Board of Trustees of the Association of California Hospitals instruct the Special Committee of Three to work for a single statewide Blue Cross Hospital Service Plan, approved by the Hospital Service Plan Commission of the American Hospital Association, and that it be brought about:

(1) By a merger of the existing Blue Cross Plans, if possible by October 1, 1944, being the preferable method. If not,

(2) By a single statewide Blue Cross Plan.

Mr. Buck stated that necessary funds would be made available to complete the program.

* * *

General discussion then followed concerning the suggestions submitted above, all members of the Committee, and Mr. Aita, President of the Association of California Hospitals, taking part.

Comment was made concerning the possibility of bringing about a merger of the three existing hospitalization groups (Hospital Service of California, Hospital Service of Southern California, and Intercoast Hospitalization Insurance Association.)

In the discussion, Dr. Kelly was asked how much hospitalization coverage is being given by California Physicians' Service at the present time, and Dr. Kelly stated that approximately 15,000 beneficiary members have contracts for such C.P.S. hospitalization coverage.

Discussion then followed concerning the set-up of the three hospitalization groups, with special reference to the complexion and mode of election of their respective Boards of Directors, etc.

Mr. Buck pointed out the importance of carrying on an educational campaign, so that those California hospitals that are not participating in Blue Cross activities would obtain a better understanding of existing trends in medical and hospitalization service, insofar as laymen are concerned.

Reference was also made to the Mannix Report, which appeared in the November, 1943, issue of California and Western Medicine, in which certain definite recommendations were made. (Page 258.)

After further discussion, it was agreed that there were no essential conflicts in the plans submitted by the Committee of Three from the California Medical Association and the Committee of Three from the Association of California Hospitals, and that a report to that effect would be made when the hospitalization representatives appeared before the conjoint Committee of Six at the hour of 11:00 A.M.

Dr. Cline, who had acted as chairman of this first meeting, suggested that Mr. Buck act as chairman of the 11:00 A.M. conference, and it was so agreed.

Recess followed.

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Minutes of the Conference of the Committee of Six with the Representatives of the Three Hospitalization Groups and California Physicians' Service.—Meeting was called to order at 11:00 A.M. in the offices of the California Medical Association, 450 Sutter Street, San Francisco, on Sunday, June 18, 1944, Mr. James V. Buck presiding.

Present:

Representing California Medical Association: John W. Cline, M.D., L. A. Alesen, M.D., and T. Henshaw Kelly, M.D.

Representing Association of California Hospitals: Mr. James V. Buck, and Mr. A. E. Maffley.

Representing Hospital Service of California: H. Gordon MacLean, M.D., and H. Houvinen, Esq.

Representing Hospital Service of Southern California: Mr. Howard Burrell, and Mr. Ritz E. Heerman.

Representing Intercoast Hospitalization Insurance Association: Mr. R. D. Brisbane.

Representing California Physicians' Service: T. Henshaw Kelly, M.D.

Present by Invitation: Mr. A. A. Aita, President, Association of California Hospitals; Mr. Thomas F. Clark, Secretary, Association of California Hospitals; S. A. Jelte, M.D., Hospital Service of California; and George H. Kress, M.D., Secretary, California Medical Association.

Chairman Buck outlined to those present the conclusions which had been drawn at the joint conference of the two Committees of Three from the California Medical Association and the Association of California Hospitals, and read to those present the resolution that had been adopted by the Trustees of the Association of California Hospitals:

That the Board of Trustees of the Association of California Hospitals instruct the Special Committee of Three to work for a single statewide Blue Cross Hospital Service Plan, approved by the Hospital Service Plan Commission of the American Hospital Association, and that it be brought about:

(1) By a merger of the existing Blue Cross Plans, if possible by October 1, 1944, being the preferable method. If not,

(2) By a single statewide Blue Cross Plan.

Mr. Buck stated that necessary funds would be made available to complete the program. He then asked the other members of his own Committee whether they concurred in his presentation, and they stated they were in full accord.

Discussion then took place concerning methods that were possible of attainment at the present time, insofar as merger and consolidation of existing hospitalization groups were concerned.

Mr. Burrell called attention to the fact that there were some 10,000 hospital beds in Southern California and 5,000 in Northern California, and if participating hospitals were each given a vote, the southern hospitals would dominate a Blue Cross hospitalization participation plan.

He also mentioned the manner in which, to a certain extent, the hospitals in Southern California had made themselves financial underwriters of Hospital Service of Southern California.

Mr. Burrell held that a single, statewide plan with one office could not carry on its work as effectively in California, as would be possible under a system with one office in San Francisco for the northern activities, and another office in Los Angeles for the southern group. Such a plan would contemplate an Executive Committee of the northern group of hospitals, and another Executive Committee of the southern group of hospitals, these two committees to form or authorize a conjoint committee with power to lay down policies, formulate a single statewide contract, etc.

Discussion followed, in which Dr. MacLean, Mr. Heerman, Mr. Brisbane, and others present took part.

Mr. Brisbane explained that, in his opinion, a single unified statewide Blue Cross Plan was unworkable. Further, that Intercoast had been having conferences with Hospital Service of California, and there was every indication that a merger could be brought into being between those two organizations.

"Dr. MacLean said he believed that it would be agreeable to the Board of Directors of the Hospital Service of California to enlarge the Board from nine members to twelve members, the three additional members to be made up of three hospital administrators, one to be picked from each of the three hospital conferences in Northern California, and that the three hospital conferences would each be asked to nominate a representative from their own conference."

In a further discussion, Mr. Brisbane stated that authority had been given by Hospital Service of California and Intercoast Hospitalization Insurance Association, and also by Hospital Service of Southern California, that their respective representatives who were present at this meeting would have power to act in relation to their respective groups.

Dr. T. Henshaw Kelly, speaking at this time as a representative of California Physicians' Service, stated that if there were one hospitalization group or committee that would have power to make policy decisions for the entire State, and elaborate a single contract, he felt such a plan would be satisfactory to California Physicians' Service at this time.

Dr. Alesen opined that the compromise plan which had been presented seemed to be workable and desirable.

Concerning the suggestion that decisions should be reached by a definite date, say October 1, 1944, it was brought out in discussion that owing to legal requirements related to mergers, as well as other factors, it was advisable that no definite date of full accomplishment be agreed upon at this time.

"Mr. Maffly stated it was reassuring to know that these plans were being made, but that they would not be adequate from the standpoint of hospitals unless hospitals elected their own trustees and completely controlled the hospital insurance plan exactly the same way the doctors control the C.P.S. This would be in line with the Mannix Survey recommendations which have been approved by both the Association of California Hospitals and the California Medical Association, namely that the hospitals themselves should completely control the hospitalization insurance groups and the physicians completely control the medical insurance group.

"Mr. Maffly stated he thought this very important because a mere merger of the two northern hospital insurance plans on the same basis as the present would not attract the hospitals to adopt this plan as their own and encourage them to lend it the support which the plan will need to really prosper in this area."

After further discussion, on motion by Mr. Brisbane, seconded by Dr. Kelly, it was voted that the representatives of the various organizations meeting at this time approve the plan of two hospitalization organizations, one in Southern California and one in Northern California (the northern group to be a merger of Hospital Service of California and Intercoast Hospitalization Insurance Association; and the southern group to be Hospital Service of Southern California); the representative board of the two to be given full authority to meet with California Physicians' Service to effect common policies and operations relating to the two organizations; and that the goal of the two organizations be a single statewide plan to be created as soon as can be reasonably accomplished. Chairman Buck called for a vote by raising of hands. The vote was unanimous.

Dr. Cline asked concerning the merger which had been mentioned as under consideration by Hospital Service of California and Intercoast Hospitalization Insurance Association, with particular reference to the time required to bring the same into operation.

Dr. McLean, in reply, stated that the legal advisors had had the plan under consideration and were ready to act at once, but that it had not been possible to take further steps until, at this present meeting the basic set-up for California might be authorized. The resolution adopted today having settled these matters, Dr. MacLean could assure those present that every effort would be made to bring about a merger of the two organizations as soon as legal procedures permitted.

In connection with the proposed plan of a conjoint Executive Committee to determine matters of policy, etc., Dr. Cline brought out the desirability of a Committee of Arbitration, representative of the two groups, with the understanding that if the two Executive Committees could not agree on certain major matters of procedure, they would agree to then abide by decisions of the Arbitration Committee.

In discussing this, Dr. MacLean felt it was undesirable at this time to suggest such an Arbitration Committee for the two executive groups. He stated that he believed the two executive groups would approach their duties in a sincere and whole-hearted manner, and if it were necessary to have an arbitration group on any particular matter, they, themselves, would be glad to provide the same.

Mr. Buck asked Dr. Kelly to tell something of the changes which had taken place in Los Angeles at the C.M.A. Annual Session, concerning California Physicians' Service, in relation to the new method of election of Administrative Members, etc.

Dr. Kelly outlined what had been done. (The details of the action taken by the House of Delegates of the C.M.A. in Los Angeles on May 7-8, 1944, are recorded in the minutes which appear on pages 329-333 of the June issue of CALIFORNIA AND WESTERN MEDICINE.) The resolutions of the three hospitalization groups, which were submitted to the Committee of Eight, also appear in that issue on page 324.

Dr. Cline added that the Executive Committee of the California Medical Association was so desirous of placing C.P.S. on a sound basis that it had voted to pay the first year's salary of an over-all, top executive for C.P.S., and that a special committee of the Trustees of C.P.S. had this matter now in hand.

Dr. Kelly also mentioned that a new set-up had been created for C.P.S. in the Southern Section of the State, with an Assistant Director who would have power to act for that territory.

Mr. Buck referred briefly to the subject of public relations, and stated that the two Committees of Three had decided a discussion of such plans would be premature at this time, and should be held in abeyance until such time as some of the objectives have been obtained. He asked if that were agreeable to all, and the answer was in the affirmative.

Chairman Buck asked if there were other business matters to come before the meeting. There being none, he expressed gratification at the progress that had seemingly been made at this meeting. In closing, he stated, however, that his Committee had received specific instructions from the Association of California Hospitals concerning certain objectives providing for a single statewide Blue Cross plan in California, and, speaking for himself and his committee, he would continue to work for the attainment of such a unified whole, feeling the conclusions reached here today were practically a means to further progress and development. Also, that the Committee of Six would continue its existence until objectives were brought into being.

The meeting was adjourned.

John W. Cline, M.D., *Chairman*,
Mr. J. V. Buck, *Chairman*,
George H. Kress, M.D., *Acting Secretary*.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Pre-Medical Students: Future Implications

Dr. James E. Paullin, retiring president of the American Medical Association, warned during the week of June 6th against "an alarming situation" in medicine, seriously threatening the public health, because so many doctors are in the armed forces and it is difficult to obtain draft deferments for premedical students.

In a nationwide CBS radio broadcast during the program, "The Doctor Fights," Dr. Paullin asserted on June 6th that "so hazardous is this situation as it relates to the health and welfare of the American people that several special committees of the American Medical Association are working seriously on this problem right now."

He pointed out that, in age groups over 45, "there are now more deaths among doctors than statistics would lead us to expect—simply because of the excessive strain placed upon these doctors by today's difficult times."

"Today with more than 60,000 doctors in the armed forces and with the Army and Navy taking more than half of the new graduates each year, an alarming situation has developed which in the future may seriously threaten the public health," he said.

"About 3,600 doctors are entering the armed services annually. There is an annual deficit each year of at least 2,200 doctors, because the vacancies created in medical ranks by death or forced retirement from practice because of age or illness cannot be filled. The reason for this lies in the difficulty of deferring premedical students, and in keeping our classes filled with otherwise draft-exempt men or with women."

He expressed gratification at the discovery in recent years of such drugs as penicillin and the sulfonamides, which, he said, "mean so much to the health and life of human beings that every doctor longs to see them made available to any human being in need of them."

"The problems of medical care are fundamental to the reconstruction and rehabilitation of our nation in the postwar period," he said. "The medical profession of this nation is willing to take the lead in planning the evolutionary changes that are bound to occur."

Medicine's most important current problem, Dr. Paullin asserted, "is the maintenance of a constant flow of physicians from our medical schools to supply the civilian population and the armed forces now and in the postwar period."

"The education of a modern doctor," he explained, "requires a period of premedical education. Even when it is accelerated to the utmost, it takes a year and a half. Then comes medical education which, even when speeded to the greatest rate, requires two and one-half years additional. Besides every doctor must have, even in wartime, at least nine months of internship in a good hospital. In peace time this may be a year or even two years of additional training."

Deferment of Doctors

There is sense in the American Medical Association protest against a selective service ruling which denies deferment to premedical students. The ruling is silly. Of course, the premedicals may be as much as eight years away from practice. But under any program the postwar order is going to need competent medical care for mind and body. If it takes eight years to make a doctor we want no shortcuts. There may be cases where refusal of deferment is justified, but a general order is wrong.—*Editorial*, San Francisco *Chronicle*.

M.D.'s at Front Guarding Mental Health

The Army is moving psychiatrists right up to the battle lines in a new move to lessen the number of mental casualties of war. In the last four months of 1943 mental affliction caused the discharge of 93,000 men, according to figures presented to congress.

These "fox-hole" psychiatrists, who will live with the men, learn to shoot their weapons, ride their vehicles and take their combat courses, will be pioneers in a new venture in "preventive psychiatry."

It will be their main job to try to prevent well men from "cracking up" under the strain of battle—instead of treating men who already have broken down. Up to now, psychiatric activity in the army has been confined mostly to hospitals, with emphasis on diagnosis and treatment.

Psychiatrists have been stationed at induction centers and at mental hygiene units in replacement training centers, but their work has largely been with men who exhibit some mental weakness at the start.

The army medical department has assigned a psychiatrist to every military division in the field—both in combat and precombat training areas—with the specific mission to "keep men mentally healthy."

"Over Age" Doctors May Be Called Into Armed Services

The War Manpower Commission on June 13th began reviewing its list of physicians previously classed as "over age" by the army and navy.

Those who can be spared by their communities will be offered the chance to apply for officers' commissions with the understanding they will be assigned to the veterans administrations. The army accordingly has raised its age limit for physicians to 63 and the navy to 55.

Physicians are classified as to "essentiality" in their communities much as are key workers in industry. The WMC said these classifications will be reviewed in the cases of the older doctors. Those who can be spared will be declared available for military service. The WMC considers one physician to 1,500 population adequate for the country at large.

Medical Plans for D-Day

Before the House of Delegates of the American Medical Association at the meeting on June 13, 1944, Major General Norman T. Kirk, Surgeon-General of the U. S. Army in his address said:

I think you might be interested in the setup of plans for D-Day when this push came across and we really started to fight this war. We have just started to fight this war. We are ready to pour men in there to win this war, and the medical department has a plan that is backing up those gallant troops that are going to make this drive to win the war.

When those units went over they attached medical companies. Two medical aid men went forward with each company that went into attack to supply first aid to the first men wounded. The litter bearers came forward to carry those men back to the aid stations that were set up on the beachhead when the battalion first landed. Then they were put on certain selected LST boats that brought over tanks and infantry and whatnot, manned by Navy personnel, Navy medical officers and Corps men who gave first aid in these LSTs, which before they left the home shore were supplied with the necessary medical equipment for dressing stations and operating rooms aboard the hospital ships that carried these battle casualties and battle sick back to the home shore, where there were ambulances and hospital trains available to take them to hospitals.

As those troops advanced, the medical battalion came in with its collecting stations and clearing stations, and those clearing stations were supplemented by surgical teams to take care of the nontransportable patients. As they advanced and a division came ashore, platoons of field hospitals and evacuation hospitals landed on the beach head to give primary surgery on the beach head rather than transport them back by boat to England for primary surgery. And so the plan is in operation as it has been studied and developed to take care of the battle casualties that ensue from this invasion.

There are general hospitals there in England that will go forward and set up in France. These units have been there operating for a year, two years, and then have been pulled out, ready to go up with their equipment to set up general hospitals in France, while newer units come over and take over the job they were doing in England. That is the plan of medical service in that theater.

I want to thank the American Medical Association for

U. S. Casualties Exceed Total of World War I

Washington, July 5.—(UP.)—American casualties in World War II have surpassed those of World War I, an analysis of the latest official reports disclosed today.

In this war, 31 months of global fighting have produced 261,541 casualties as compared to the 259,735 casualties accumulated during the 19 months of United States participation in the last conflict.

A breakdown by categories shows:

This war—56,772 dead, 107,938 wounded, 55 903 missing and 40,928 prisoners of war.

Last war—53,878 dead, 201,377 wounded, and 4,480 prisoners.

The World War II figures were taken from four nonconflicting, nonduplicating announcements:

1. The official War Department announcement of 179,923 Army casualties through June 13 but not counting losses in Normandy and Saipan.

2. The official Navy Department announcement of 47,704 Navy, Marine Corps and Coast Guard casualties as of July 5, exclusive of losses on Saipan.

3. The announcement by the Supreme Allied Command of 24,162 U. S. casualties in Normandy through June 20.

4. Admiral Chester W. Nimitz' announcement of 9,752 casualties on Saipan from the time of the landings on June 15 up to June 28.

Analysis of these figures provides the following breakdown by category and service:

World War II to Date

	Dead	*Wounded*	*Missing*	*Prisoners*	*Totals*
Army	35,289	87,812	45,776	36,467	205 344
Marines	5,851	14,333	1,688	1,944	23,816
Navy and Coast Guard	15,632	5,793	8,439	2,517	32,381
Totals	56,771	107,938	55,903	40,928	261,541

To arrive at a comparable table for World War I, Army casualties were obtained from the War Department, which said those contained in the Secretary of War's annual report of 1926 had been officially announced as final. The Navy, Coast Guard and Marine Corps casualties were supplied by the Navy Department after a recent recapitulation.

The World War I totals are at variance with those in some reference works which generally show not only those killed in action, dead of wounds and lost at sea, but also those dead from disease and accident. In the following table—as in the World War II breakdown—only those who died in action, died of wounds, or have been definitely established as lost at sea, are listed among the dead:

World War I

	Dead	*Wounded*	*Prisoners*	*Total*
Army	50,510	193,663	4,480	248,653
Marines	2,475	7,714	....	10,189
Navy and Coast Guard	893	......	....	893
Totals	53,878	201,377	4,480	259,735

The official records for World War I show no Marine prisoners, but some are believed to have been included in the Army figure. No missing for any service are shown in the table for the last war because, by the time official figures were compiled, persons listed as missing either had returned to duty or had been listed as dead.—San Francisco *News*, July 5.

the help that it has given the Surgeon General's Office in selecting specialists and making available this information about doctors as to what they can do and not what they think they can do. With the help in our office of such men as General Rankin and Hugh Morgan and others from you who have come in to assist us, those men have been placed on the jobs where they are doing excellent work. With 40,000 men in the Medical Department and with excellent care that we are seeing that the sick and wounded are receiving, it isn't by chance that this all happened. It was planned, and the right man was put in the right job to do that job.

I thank you for allowing me to talk to you. I am afraid I have talked too long.

On Plans for Post-War Use of Wartime Hospitals

Eight of every 10 men accepted for armed services had physical defects, Selective Service Director Hershey will tell Senate subcommittee next week. How these eight were made fit will be told by Surgeon General of Navy, Admiral Ross T. McIntire. Committee members may ask why similar miracles weren't performed on thousands of rejectees.

Hearings, presided over by Senator Pepper (D., Fla.) will pave way for legislation he plans to assure full post-war use of wartime hospitals, clinics.—"Washington Calling," in San Francisco *News*, July 8.

Cadet Nurse Corps

The United States Cadet Nurse Corps has exceeded its first year quota of 65,000 recruits by more than 500, Dr. Thomas Farran, Surgeon General of the Public Health Service, reported on June 30.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The address of the three libraries follow:

University of California Medical Library, The Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco. California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps

Hospital Corps School to Open in San Diego

The Navy's largest hospital corps school, with a capacity of 2,500 "students," will be placed in operation in Balboa Park, San Diego, during July, 11th Naval District headquarters announced on June 30.

A hospital corps school located here for several years will be combined with one now at the Great Lakes Naval Training Center, Illinois, in the new facilities. Twelve weeks' training will be provided to prepare hospital corpsmen for duty with the Navy and Marine Corps.

Floating Hospitals

Floating hospitals are now going to sea as part of our regular convoy escorts, it was disclosed during the Navy trial run of the PCE (R) 853 (patrol craft escort, rescue) in Lake Michigan.

These vessels contain bunks for 57 passengers and have complete hospital facilities, including a doctor, operating table, dispensary and X-ray machines.

Like other PCE craft, which do not have the hospital facilities, these rescue ships are manned by seven officers and 100 men. In addition to their rescue work, these craft, it was pointed out, make excellent vessels for following up landing craft in invasions.

Military Clippings.—Some news items of a military nature from the daily press follow:

A.M.A. Attacks Drafting of Pre-Medical Students; Asks President Roosevelt to Change Policy

Voicing bitter protest against Selective Service for banning deferment of all pre-medical students after July 1, the House of Delegates of the American Medical Association called upon the President or Congress to "correct the current drastic regulations," which the physicians said "threatens the health and well-being of our citizens."

Meeting in Chicago during the A.M.A.'s 94th annual convention, the delegates adopted a resolution condemning "the present policy of the Army and the Selective Service System in preventing the enrollment of a sufficient number of qualified students" during wartime. Copies were wired to President Roosevelt, Congressional leaders, the War Manpower Commission and other governmental agencies, stating that "immediate action is imperative."

The action was taken on the opening day of the five-day session, only a short time after Dr. James E. Paullin, of Atlanta, the retiring president, told the delegates: "It can be readily seen that a very serious situation will soon face us."

"The accelerated medical training program," Dr. Paullin said in his address, "contemplates 6,000 students each year. At the beginning of the program 55 per cent of the places were to be filled by the Army; 25 per cent by the Navy; and 20 per cent by women, physically disqualified men, and those deferred by Selective Service. This was bad enough, but a recent directive from Selective Service, in which after July 1, 1944, there will be no deferment for pre-medical students, stops abruptly the entrance in 1945 of practically all desirable students who are not either physically disqualified or women, to whom we can look in the near future to supply medical care for civilian needs. When it is realized that there is already an annual deficit of at least 2,200 physicians caused by death or forced retirement from civilian practice beyond the 1,200 who graduate with deferred classification, it can be readily seen that a very serious situation will soon face us."

* * *

President Roosevelt Refuses to Defer Pre-Medical Students

Washington, July 5.—(UP.)—President Roosevelt today refused to order a change in the Selective Service ruling banning deferment of pre-medical students beyond July 1, as he had been asked to do by Rep. A. L. Miller (R., Neb.).

Rep. Miller wrote the President on June 16 asking that he review the no deferment order affecting pre-medical students. The White House today made public the President's reply in which he said, "the need of the armed forces for young, vigorous men" is paramount.

Mr. Roosevelt said the inter-agency committee on deferments, formed to advise Selective Service on deferment of men under 26, had pointed out that present pre-medical students could not be of service in medical practice before 1948, and that "many of them would never practice medicine."

The President said young men who are physically unfit for armed service are available for pre-medical training and that, so far as the future supply of doctors is concerned, many ex-servicemen will desire to begin the study of medicine.

The President said servicemen who want to study medicine should be "given every opportunity in the way of education and training." He added that medical colleges were "particularly interested" in promoting this type of medical education.—San Francisco *News*, July 5.

COMMITTEE ON MEDICAL ECONOMICS

New Accident and Sickness Claim Forms

As a step to relieve the burden imposed by war conditions on the medical profession, the adoption of two new short simplified statement forms to be filled out by physicians for their patients who have accident or sickness claims under personal accident or health policies is being recommended by The International Claim Association and the Health and Accident Underwriters Conference to companies writing these forms of insurance.

Introduction of the new forms, The Association believes, will be an advantage not only from the physician's standpoint but also in enabling policyholders to establish their claims more promptly.

The new physician's statement blanks have been drafted jointly by the Medical Conference Committee of the Claim Association headed by A. G. Frankhauser of the Continental Casualty Company of Chicago and a special committee of the Underwriters Conference headed by George W. Young, Secretary of the Inter-State Business Men's Company of Des Moines. These committees have had the interested coöperation of Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association and also of the Governing Committee of the Bureau of Personal Accident and Health Underwriters.

The questions on the simplified blanks are designed to bring out the facts necessary to establish the claim. All other questions have been eliminated. No notarial acknowledgment or other certification by the doctor is required.

Attending Physician's Statement—Sickness

Name and address of insurance company.
Patient's name.
Address.

1. Diagnosis ....
   Please explain complications, if any.
2. When did patient first consult you for this illness?
   (Date) ....
3. When did first symptoms appear?
   (Date) ....
4. What operation was performed, if any?
5. Was patient confined to the house?
   From (Date)............ to (Date)............
   Was patient confined to a hospital?
   From (Date).............. to (Date)..............
   Name of hospital?
6. Dates of treatments?
   Office (Dates).......... Home (Dates)..........
7. When was, or will patient be able to resume any part of his work?
   Date ....
   If you wish to amplify, please use this space.
   Date ....
   Signed ....
   Street and No.........Town..........State........

*Attending Physician's Statement—Accident**

Name and address of insurance company.
Patient's name.
Address.

1. Please describe injury received....................
   Date of accident..................................
2. What operation was performed, if any?
3. Please give dates you attended patient for this injury........... Office........... Home.........
   Patient hospitalized? From (Date)................
   to (Date)................ Name of hospital?
4. How long was, or will patient be totally disabled?
   From (Date) .... to (Date)...........
   If you wish to amplify, please use this space.
   Date ....
   Signed ....
   Street and No.........Town.........State.........

*(Note: The San Francisco County Medical Society, in its "Bulletin" for July, printed two short insurance forms for sickness and accident reports that had been prepared by the Society's special committee, in line with the above. On each of the forms it is stated that if a more detailed report is required, a charge for same will be made, the cost to be borne by the carrier. The forms are available through the office of the San Francisco County Medical Society at cost, $1.25 per hundred. Reference was also made thereto in CALIFORNIA AND WESTERN MEDICINE, for June, on page 341.)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Free Medical Care Initiative Proposed

The "California Plan for Free Medical Care" is the name of a proposed initiative measure, written and prepared by Dr. George H. Sciaroni, of Fresno, to be submitted to the voters of the State of California, presumably in a special election.

This plan provides that medical care shall be made available to every citizen of this state, regardless of social position or ability to pay.

The health of every citizen is vital to the strength of our nation. Many lives have been blighted and many otherwise useful citizens have been lost to the community because they could not afford the proper medical care which would have saved them misery and unhappiness, and restored them to their rightful places in civic life.

The Fresno Central Council was the first to officially endorse Dr. Sciaroni's plan, which is now being acted on by other labor councils throughout the state.—Fresno *Labor News*, June 2, 1944.

Government Control a Disaster

Socialized medicine would mean greater security for doctors. Therefore, the medical profession, in opposing socialization, is not grinding the ax of personal gain. This is hard for medical critics who think comfort is the millennium, to understand.

Doctors oppose government domination of medicine for two reasons: First, because it would lower medical standards and bring about inferior medical service to the people. Second, because, as American citizens with a background of freedom and individualism, they have no alternative but to oppose any measure which they feel is a threat to American institutions and Constitutional government. Socialized medicine, like socialization of industry, would hasten the end of freedom in this nation.

The doctors have been accused of selfishness and blind conservatism in their battle against government medicine. If they were selfish they would not be killing themselves trying to maintain the health of the nation during the present crisis. They are far from blind conservatives, because more than anyone else, they come into contact with misfortune and death. They are working constantly to broaden and improve medical care. Some measure of their success is indicated by the fact that the span of life in the last century and a half has been increased from 35 to 62 years—almost doubled.

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† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

For address of California Public Health League, see adv. page 6.

The attitude of physicians on the issue of socialized medicine has been well described by Rear Admiral Ross T. McIntire, the president's physician. "It is my hope that we shall never see the practice of medicine or anything else that has to do with it come under government control. It would be a disaster to this country."—Editorial in Isleton *Journal*, May 26.

MATERNITY-PEDIATRIC PLAN OF FEDERAL CHILDREN'S BUREAU*

ITEM LIII

Pressure on Congress for E.M.I.C. Bureau Funds Hit

House Committee Assails Propagandizing by Federal Employees for Appropriations

The third major money bill reported in less than a week—a $1,104,972,814 supply measure for independent offices—was used by the House Appropriations Committee on May 27 as the medium for a verbal slap at Federal employees who "propagandize" Congress for money.

Directing its criticism at the Children's Bureau and the Office of Education, the committee referred to a "considerable amount of correspondence" in connection with the Children's Bureau and to the "particularly aggressive" attitude of the Office of Education with respect to funds.

"The time of government employees should not be utilized in propagandizing the Congress in behalf of appropriations from which they might expect to benefit," the committee said, nor should the employees be used in having members of Congress "circularized" in behalf of appropriations. . . .

The committee eliminated entirely a request for $2,465,000 for the War Manpower Commission's program of recruiting, locating and importing foreign workers to meet labor shortages, commenting that the program has not met with "sufficient success to justify its continuation."

Other allotments included $42,800,000 for emergency maternity and infant care for wives and children of enlisted servicemen and $63,000,000 for the emergency nurses' training program.

The Children's Bureau administration of medical services given dependents of enlisted men has aroused the indignation of the medical profession, Dr. William Benbow Thompson of Los Angeles informed the committee.

Dr. Thompson, who said he represented the California Medical Association, told committee members during hearings on the bill:

"It distresses us, practicing physicians, that we should be cleverly placed in the light of antagonism to a program beneficial to and needed by the wives and children of men fighting to preserve the free institutions of free America.

"We are not so opposed; it is the administration of the program that has aroused our ire."

Dr. Thompson listed as an "example of a bureaucracy run wild" the bureau's requirement that clinics must be among facilities available for "the free choice of the dependents."

"Our established clinics," said Dr. Thompson, "are for the indigent. Must these, who cannot go elsewhere, be crowded out by the admission of service dependents? Or are the dependents considered by the Bureau as in the pauper class?" . . .

ITEM LII

Emergency Infant and Maternity Care in California

During April, 2,866 new cases, involving 2,691 maternity patients and 175 infants, were accepted under the emergency program sponsored by the Federal Government through the Children's Bureau of the Department of Labor with the coöperation of the California State Department of Public Health. Since the program started in July of 1943, 19,621 maternity patients, who are wives of service men, have been accepted for medical care and hospitalization at the expense of the Federal Government. Of these, 7,745 have completed their treatment and hospitalization, which brings the current case load to approximately 12,000 cases. A total of $830,500 has been paid to date to physicians, hospitals, and nurses for services rendered under the program. Bills for services have been received from 1,735 participating physicians and 281 hospitals that provide the required facilities for hospitalization.

* * *

During May authorizations were issued for medical and hospital care of 3,187 maternity patients and 167 sick infants of men in the armed forces. Meetings were held with committees of the California Medical Association in Los Angeles and San Francisco in connection with the present new policies of the Children's Bureau in the development of a program for Emergency Maternity and Infant Care.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Los Angeles County Hospital

The Los Angeles County Hospital (the M. D. division of the Los Angeles County General Hospital) is one of the large hospitals of the United States. The editor of "The Bulletin," of the Los Angeles County Medical Association, Dr. E. T. Remmen, in a recent issue gave the following interesting account of some of the present activities of that institution:

The Los Angeles County Hospital, one of the nation's great medical institutions, like all other hospitals in this area, is feeling the impact of rapidly increasing population with its need for medical and hospital care. On May 30, a typical day, the medical units of the hospital had 2,530 inpatients under care, which was an increase of 407 patients over the same date a year ago. This inpatient population is distributed among the various services which include, in addition to general medicine and surgery, the usual division into specialties. Each is a separate service with its own attending staff, resident physicians, and interns.

The daily accumulated average in patient load for the current fiscal year to date (July 1, 1943 to May 30, 1944) was 2,466 as compared with 2,175 a year ago. The highest peak in patient load this year was on March 18, when the house count was 2,798. On the same date the previous year the count was 2,266. For this entire fiscal year the hospital has been consistently caring for from 350 to 500 more patients daily than in the prior year. This has taxed the medical and nursing personnel to its utmost.

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* Maternity-Pediatric items listed in Roman numerals. CALIFORNIA AND WESTERN MEDICINE for July (Items I to XVIII); September, pages 178-182 (Items XIX to XXIII); October, pages 226-231 (Items XXIV to XXX); November, pages 282-284 (Items XXXI to XXXVII); December, page 342 (Items XXXVIII and XXXIX and page 304), January, pages 31-32 (Items XL and XLI); February, pages 76-77 (Items XLII and XLIII); March, page 110 (Items XLIV and XLV); April, page 221 (Item XLVI); May, page 259 (Items XLVII to LI).

The attending staff of the hospital includes about 600 physicians, who, although engaged in private practice, give their services without compensation. They supervise the care and treatment of patients and instruct and direct the interns and residents assigned to their respective services. Membership on this staff is by qualification and selection by a medical advisory board. Appointments are made for a one-year period by the hospital administration on recommendation of this board. Reappointment may be made annually. Now 184 members of the staff are on military leave of absence. Philip Cunnane, M. D., is chief of staff, J. Norton Nichols, M. D., is chairman of the surgical section, and Howard F. West, M. D., is chairman of the medical section.

The War Manpower Commission (Procurement and Assignment Service) has limited the number of interns and resident physicians who may be employed. The hospital's allocation of interns is 79 as compared with a normal of 120. Resident physicians are limited to 43 as compared with a normal of 65. Effective October 1, 1944, a new quota will allow the hospital 84 interns and 46 residents. In addition, about 40 full time paid physicians serve the admitting and outpatient departments in tuberculosis, psychopathy, communicable disease, pathology, radiology, anesthesia and in administrative positions.

The outpatient department of the hospital is an important and a very heavy service. In addition to the special clinics conducted within the hospital, its clinics care for outpatients who are residents of the metropolitan area of Los Angeles. Outpatients in the outlying territory of the county are attended by physicians on the Outside Medical Relief Staff in their own offices and in the patients' homes. Were it not for their active and conscientious support of this medical program, the demand upon the facilities of the County Hospital would undoubtedly exceed its capacity. During the past fiscal year, July 1, 1942, to June 30, 1943, the Outside Medical Relief Staff handled 47,459 patient office visits and 9,013 home calls. In this fiscal year, July 1, 1943, to April 30, 1944, 24,893 office visits and 7,200 home calls were made. During the same periods the Outpatient Services within the hospital had 242,472 and 175,346 patient visits, respectively.

Two medical schools, those of the University of Southern California and the College of Medical Evangelists, carry on teaching programs in the institution and through their presence and activities contribute greatly to the care of the indigent sick and dependent poor of the County. Because of the relationship of these two medical schools with the hospital and its outstanding attending staff organization, it is fast becoming recognized as one of the better teaching institutions of the country. While a majority of the interns and residents on the House Staff naturally come from the two local medical schools, there are many from other schools of the United States and Canada. Because of the size of the institution and the magnitude and diversity of its clinical material, internships and residencies in this hospital are much sought and are generally at a premium. The department of pathology will soon undergo some reorganization and realignment because of the retirement on July 1, 1944, of Newton Evans, M. D., who has been chief pathologist since 1928. Of special interest is the fact that autopsies are performed in 60 per cent of all deaths.

Many nurses have been lost to the Nursing Corps of the Armed Forces as well as to the more lucrative positions incidental to the war effort and its industries. The hospital has a total roster of 517 registered nurses, but counts its effective "on duty" staff at 326 as compared with a minimum normal requirement of 380 for its current case load. The dearth of registered nurses for the care of civilian needs is becoming a matter of grave and increasing concern to doctors and hospital administrators.

The War Manpower Commission expects all hospitals, public and private, to further reduce nursing hour ratios per patient in order to provide the essential nurses for Army, Navy and Veterans' hospitals. The County Hospital has a large and effective School of Nursing. The present enrollment is 540. Only 25 are not enrolled in the Cadet Corps which is under subsidy of the United States Public Health Service. Two hundred ninety-five are in the first period of training, 143 in the second, and 102 in the third. These student nurses are of invaluable assistance in the bedside care of the patients. A new class of 100 student cadets will be enrolled in August. Although 40 will be graduated by September, the hospital school will still have a fall enrollment of 600. The Los Angeles City School Board and City College have assigned several excellent instructors to the school. The administrative and service departments have also suffered from shortage of personnel.

The operation of an institution of the magnitude required for the constant care of such a large segment of the population of the community necessarily takes a budget of no mean proportions. For the fiscal year commencing July 1, 1944, during which it is estimated that the County will be required to furnish hospital care for a daily average of 2,950 patients, of which 2,720 will be in those departments under the care and jurisdiction of Physicians and Surgeons, M. D., the General Hospital has been allowed an over-all budget in the tentative amount of $6,456,083, of which $5,386,523 is for salaries and wages, $1,046,708 for maintenance and operation, and $22,852 for capital outlay. During the war years and because of governmental restrictions upon vital materials, the County Hospital of necessity has drastically curtailed its program of replacement of obsolete and purchase of new capital equipment.

The hospital, in coöperation with the two medical schools, is already making plans which will permit the scores of young doctors, whose medical training and study of the various specialties were interrupted by the war, to resume their training by making every facility available to them when the war ends.

The County Hospital, a unit of the General Hospital, which is a division of the Department of Charities, is administered by Leroy R. Bruce as General Superintendent with John E. Smits as his assistant and Phoebus Berman, M. D., as Medical Director. Mrs. Edith B. Pilant, R.N., is Director of Nursing Services while Mrs. Elizabeth H. Brown is Director of the School of Nursing.

Hospital Service of California

Donald D. Lum, president of the Alameda County Medical Society, gave the following account of the H.S.C., in his President's message of June 19:

The growing interest in medical and hospital insurance makes fitting a review of the plan initiated by the Alameda County Medical Association and local hospitals.

It was actually inaugurated on November 16, 1936, to lighten the burden of heavy hospital bills for people of moderate means. Participation by the public was voluntary, with free choice of doctor and hospital. The result was immediate success, and since that time, Hospital Service has made substantial progress. Moreover, because of a sound, conservative policy, not only have hospitals been paid in full, since the inception, but a considerable reserve fund has been built up to face possible epidemics, disasters, and inflation.

Today, the Directors are gratified to note 80,000 Bay area subscribers, with reserves amounting to half a million dollars, which represents approximately $6.00 per subscriber. This gain is ample indication not only of a conservative policy, but of extremely modest overhead expense so essential to sound business operation.

Because of this satisfactory record, benefits to subscribers have been increased no less than three times without additional cost to the subscriber. In May, 1943, five additional benefits were granted all subscribers, so that today, Hospital Service of California provides a service among the most liberal of any Blue Cross Plan in existence. At that time, an indemnity plan was offered for surgical operations, fractures or dislocations, which provided a schedule of payments direct to the subscriber without, however, prejudicing or indicating what the surgeon's fee should be. So popular was this offer, that to date, over 20,000 subscribers have added this benefit.

COMMITTEE ON ORGANIZATION AND MEMBERSHIP

De Senectute

"When thou wast young, thou girdedst thyself, and walkedst whither thou wouldest: but when thou shalt be old, thou shalt stretch forth thy hands, and another shall gird thee, and carry thee whither thou wouldest not."—John 21:18.

Age seems only a brief second progressing in the scheme of time. Old age then is like the minute that has just passed to make room for the hour. Have you ever been able to actually picture yourself as the old duffer who came to visit the office today. Few humans have! We lack the ability to imagine ourselves as we will be in old age, because when eyes are clear and limbs are tireless, there is no incentive to imagine the breakdown of body functions into future inadequacies. However, surveys into the plight of the aged reveal that need exists for preparing for possible lack of capacity to earn and save even on the part of medical oldsters.

The medical profession as a whole has as yet no available plan for its own members. Other professionals and laborers are constantly striving to perfect forms of insurance and saving for this purpose. It is recognized that difficulties arise when an attempt is made to make monthly contributions on a permanent basis. Those of us engaged in private practice have no set income. Also the expenses incurred vary from month to month. This fact alone has probably been the main deterrent in any actual trend of policy on this subject. The Los Angeles County Medical Association has for a long time been aware of the acute need for creating more active and efficient interest in the situation. As a result the first definite step was taken organizing the Physicians' Aid Association. It is designed to care for those of us who become dependent. It also provides for the care of our families in time of need. Already a fund of $45,000 has been subscribed by our members. Several gifts of $1000 have already been received. In order to carry out definite and effective plans of aid it is recognized that small efforts toward the goal on the part of all of us will make such an undertaking successful. There is no need for any burden to fall on one small group. It is hoped that a hundred per cent interest will bring the coöperation to a peak and give ample funds to cover all needs.

This is not an appeal to charity! A contribution from each of us is an assurance that the giver—come what may—will have a comfortable home with congenial companions.—Secretary E. T. Remmen, in *"Bulletin* of Los Angeles County Medical Association."

COUNTY SOCIETIES[†]

CHANGES IN MEMBERSHIP

New Members (18)

Alameda County (4)

Condit, Philip K., *New York*
Eliassen, George W., *Oakland*
Knopf, Benjamin W., *Livermore*
Wilbur, William A., *Hayward*

Napa County (1)

Robson, Verna L., *Sanitarium*

Sacramento County (1)

Patton, Fred P., *Sacramento*

San Diego County (1)

Rumsey, J. M., *San Diego*

San Francisco County (9)

Anderson, Hamilton H., *San Francisco*
Biernoff, Joseph, *San Francisco*
Bostick, Warren L., *San Francisco*
Brennan, Thomas J., *San Francisco*
Buckley, Daniel H., *San Francisco*
Claffey, Edward Christopher, *San Francisco*
Johnson, Nelson W., *San Francisco*
King, Earl B., *San Francisco*
Meilstrup, Drew Buckle, *San Francisco*

Ventura County (1)

Sherwood, Catherine, *Santa Paula*

Yuba-Sutter-Colusa Counties (1)

Keyes, Thomas F., *Marysville*

Transfers (2)

Childrey, John H., from San Mateo County to Santa Clara County.

Wirth, R. G., from Los Angeles County to San Diego County.

In Memoriam

Hoskins, Greg. Died at Long Beach, May 10, 1944, age 57. Graduate of the Cooper Medical College, San Francisco, 1910. Licensed in California in 1911. Doctor Hoskins was a Retired Member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

*

Profant, Henry James. Died at Santa Barbara, April 29, 1944, age 51. Graduate of the Rush Medical College, Illinois, 1920. Licensed in California in 1921. Doctor Profant was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

*

Schoff, Charles Edward. Died at Sacramento, May 28, 1944, age 59. Graduate of the Cooper Medical College, San Francisco, 1908. Licensed in California in 1908. Doctor Schoff was a retired member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

[†] For roster of officers of component county medical societies, see page 4 in front advertising section.

OBITUARY

Ruby L. Cunningham

1880—1944

Dr. Ruby L. Cunningham of Berkeley, Calif., who for many years served as senior women's physician at the Cowell Memorial Hospital, and as Associate Professor of Hygiene at the University of California at Berkeley, passed away on June 25th after an illness of several months. She was born in Riverside County, California, and after graduating from San Bernardino High School came to Berkeley to attend the University of California, where she was awarded the B.S. degree in 1903. She taught science in several California high schools and later returned to the University where she received her M.S. in 1912 and an M.D. in 1914, serving her interneships at the San Francisco Hospital.

Before joining the Health Service Staff of the U. C. in 1918, she was engaged in private practice in Berkeley. She succeeded Dr. Romilda Paroni, and became assistant and later associate professor of hygiene and senior physician for women. For over a quarter of a century she devoted full time in administering to the health of women students at the University of California and to the teaching of hygiene. Her kindly spirit will be remembered by thousands of university women whom she served, and as a true physician and teacher.

Dr. Cunningham was a member of the Alameda County Medical Society, the California Medical Association and the American Medical Association. She was also a member of the American Student Health Association, serving at one time as vice-president and member of the Council. She was past president of the Pacific Coast Section of the American Student Health Association at the time of her death, and one time president of the Berkeley Health Center. She held a membership in the Sigma Xi and Delta Omega national honor societies. She took an active interest in women's campus activities, was a charter member of the Women's Faculty Club, a member of the Prytanean Society and Mortar Board. She made many scientific contributions to medical science and published several papers on students' health problems.

Dr. Cunningham had lived with her sister, Mrs. Mathew C. Lynch, at 1830 Yosemite Road, Berkeley, Calif., for several years prior to her death. Her untimely passing is greatly regretted by all with whom she was associated.

Robert T. Legge, M.D.
Berkeley, Calif.

So that my life be brave, what though not long?
—William Drummond, *Sonnets,* No. xii.

In their rôle of scavenger, mussels devour a great variety of dead cells and organic particles, including fragments of cellulose, granules of starch, and oil globules and protein particles, it is revealed in a recent article in the "Journal of Experimental Zoölogy" by Dr. Fox and Dr. Wesley R. Coe, Professor Emeritus of Zoölogy of Yale University.

Although their principal food consists of refuse, mussels also consume large numbers of microscopic plants and animals. In filtering about 60 quarts of water a day, a mussel may take in some 6,600,000 tiny dinoflagellates and possibly 1,200,000 diatoms, Dr. Fox says.

While mussels will not swallow anything poisonous to their own systems, they do ingest the minute organism Gonyaulax which is very poisonous to man. For this reason, human consumption of mussels must be banned in certain localities for a period during the summer when Gonyaulax flourishes.

CALIFORNIA PHYSICIANS' SERVICE†

California Physicians' Service and Its Public Relations

(A series of articles: January, "California and Western Medicine," on page 38; February, page 83; March, page 118; April, page 227.)

Professional members of California Physicians' Service have long since become accustomed to the use of the words "unit" and "unit value" in connection with their C.P.S. work. However, in some cases they do not actually understand all that is embodied in those words, nor do they realize the forces which bear upon the ultimate unit paid for professional services. A brief review of the unit seems to be in order at this time.

The "unit" in itself is an abstract term of measurement, much as one horsepower or one foot-pound, arbitrary selections for specific purposes. For purposes of C.P.S. the unit is fixed as an arbitrary fee, in the abstract, for a specific service: Concretely, it attains a monetary value in accordance with (1) the number of units of professional service rendered by all professional members in a given period and (2) the amount of money available for the payment of units of service rendered during that same period. Thus, if 10,000 units of service are rendered during one month, and if $22,500 in cash is available for professional services for that month, the unit value may be fixed at $2.25.

Ideally, the unit has a value of $2.50. By the terms of the C.P.S. articles, the unit may never attain a value greater than $2.50; however, there is no prohibition anywhere against increasing the number of units which may be paid for one or another specific service. Indeed, some services which have been considered underpaid in the past have been increased in value through the allocation of additional units for such services.

The Unit and the Doctor

When the professional member joins C.P.S. he agrees to accept the going number of units, at the going value, in full payment for his professional services. He realizes, or he should realize, that the value of the unit fluctuates in accordance with the amount of cash collections for the period covered and in accordance with the number of units of service rendered for the period. If the professional member becomes too liberal in the amount of service given a beneficiary member, or if a beneficiary member makes too great a demand for medical service, it is obvious that the number of units of service rendered must increase and that the unit value must similarly decrease. Any waste in the volume of service rendered is immediately reflected in the value of the unit for the period. Either the physician or the patient may take money right out of the doctor's pocket by running up the number of units of service rendered.

On a comparative basis, the various medical and surgical procedures are gauged by a table of unit values which fixes an agreed-upon number of units for each item. In some cases the number of units allowed represents the fee for a complete case, including preparation, operation and after-care. In other cases the unit allowance covers only a specified procedure, with additional units allowed for subsequent visits and treatments.

To bring the unit and its value down to the realm of dollars and cents, the professional member is naturally inclined to compare C.P.S. payments with those he receives from his private patients. In some instances the comparison is unfavorable to C.P.S. In most instances, an honest comparison of fees shows that the C.P.S. unit payment for certain services represents as much as, or even more than, the physician would receive from his average private patient in the lower-income bracket for the same service.

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† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

Just to give a few examples of some of the more common procedures, the following list of C.P.S. unit allowances, together with their value on the basis of a full $2.50 unit and also on the basis of the $2.25 unit now being paid, may be illuminating:

Service	*Units*	*@ $2.50 unit*	*@ $2.25 unit*
Office visit (first)	2	$ 5.00	$ 4.50
Office visit (subsequent)	1	2.50	2.25
Hospital visit	1½	3.75	3.37
Home visit (first)	2	5.00	4.50
Home visit (subsequent)	1½	3.75	3.37
Home visit after 10 p.m.	3	7.50	6.75
Herniotomy	40	100.00	90.00
Appendectomy	50	125.00	112.50
Hemorrhoidectomy	40	100.00	90.00
Nephrectomy	80	200.00	180.00
Fractures: arm	25	62.50	56.25
wrist	25	62.50	56.25
femur	40	100.00	90.00
Assist at major operation	12	30.00	27.00
Assist at minor operation	4	10.00	9.00
Obstetrics	40	100.00	90.00
Hysterectomy	60	150.00	135.00
Prostatectomy	80	200.00	180.00
Colostomy	50	125.00	112.50
Gastrectomy	80	200.00	180.00
Cholycystectomy	80	200.00	180.00
Myringotomy	4	10.00	9.00
Audiometer test	2	5.00	4.50
Submucous resection	30	75.00	67.50
Caldwell-Luc	70	175.00	157.50
Foreign body in eye	2	5.00	4.50
Thyroidectomy	70	175.00	157.50
Reduction nasal fracture	10	25.00	22.50
Electocardiogram	3	7.50	6.75
Internist: work up case	6	15.00	13.50

(Add 50% for compound or comminuted fracture or where traction is used. Add 100% for open reduction.)

(Plus standard laboratory fees)

A review of these figures indicates that the average C.P.S. fee for these services, either on the basis of the full unit or on the basis of the $2.25 unit now being paid, represents an eminently fair collection for services rendered. This fact becomes increasingly apparent when the following facts are kept in mind:

1. The payment from C.P.S. is a full payment, with no collection loss.

2. The method of collection has been simplified to a point where the office or paper work involved is less than similar work for a private patient.

3. There is no delay in collections; payment for a specified month is made at a specified time of the following month.

4. Only one statement is sent out; there is no billing of unpaid balances from month to month.

5. All payments due from C.P.S. may be charged for in a single mailing to C.P.S.; payment for all such items is made by C.P.S. in a single check.

6. In cases of surgery, the fee of an assistant is allowed; the surgeon does not have to pay this fee out of his own fee.

7. In cases where x-ray or laboratory work is necessary, full payment is made by C.P.S. for such services, either to the attending physician or to the specialist to whom such work is referred.

With the above facts in mind, how do these C.P.S. fees compare with the average fees you collect—not what you originally charge—for similar services to low-income patients? How do these fees compare with the fees received from insurance carriers for industrial compensation practice?

These questions are not asked in an impertinent vein but merely for the purpose of inviting comparison. It becomes apparent, when a calm comparison is made, that the C.P.S. fees represent eminently fair fees for the type of service rendered to patients in the low-income groups which make up C.P.S.

In some metropolitan areas the average fees for some of the listed services may appear higher, on the surface, than the fees C.P.S. is now paying. On the other hand, when collection losses and collection expenses are taken into consideration, and when the certainty of payment on a specified date is balanced against the office work and uncertainty of payment involved in many private cases, the C.P.S. fees assume a more favorable comparative value.

On a state-wide basis, which must necessarily be used in considering a state-wide organization, the C.P.S. fees represent a level of fees which compares most favorably with the average of private medical and surgical fees.

Naturally, the value of C.P.S. fees comes back to the unit value which can be paid. And here is where the professional members not only influence but actually control the unit value. By limiting their services to the essentials and thereby not wasting units of service, they can reduce the total volume of units and make possible a more nearly ideal unit value. By giving their C.P.S. patients the best in medical service they can gain new friends for medicine and for C.P.S., and can help build up the total number of beneficiary members; this will help reduce the per capita overhead expense and make more money available for payment of units.

Here is the doctor's opportunity to contribute to his own good and to the good of the profession as a whole. Here is the profession's chance to meet a challenge issued by the public, a challenge which must be adequately and properly answered if Medicine is to continue in control of its own destinies.

U. S. Losses Listed

The war up to June 22, 1944, has brought 178,677 casualties to the Army and 46,705 to the Navy.

The Army casualties cover a period through June 6; the Navy total is on the basis of a report made public June 22. The total of 225,382 for both services is an increase over figures announced two weeks earlier. This increase includes casualties suffered on the first day of the invasion of Europe.

Of the *United States Army* casualties, 31,289 are dead, 71,432 wounded, 39,976 missing and 35,980 prisoners. The campaign on the Italian mainland, from the landings on September 9 through June 15, brought 64,992 casualties, of whom 11,610 are killed, 44,246 wounded and 8,956 missing.

American Airmen operating from Italy against targets there and in Nazi held Europe have lost, during the same period 1,186 killed, 1,373 wounded and 6,493 missing—a total of 9,052.

The *Navy* figures of June 22 showed an increase of 932 since an announcement two weeks earlier. It is believed that the intense Navy, Marine and Coast Guard activity in the Pacific during recent weeks and days is not yet reflected in the Navy totals. The latest Navy figures place the killed at 20,044, wounded at 12,905, the missing at 9,295 and prisoners at 4,461.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

On Regimentation of Doctors and Patients.*—*"Medical Care"* is a quarterly journal devoted to economic and social aspects of health service. Its editorial in the February, 1944 issue has the caption "Nineteen Forty-Three: An Editorial Review," the author presumably being Michael M. Davis, Editor. An excerpt follows:

> "*Three Tasks Ahead*
>
> "While controversy advertises and experience illuminates the issues of medical care, there is time for three essential tasks:
>
> "1. The first task is to define, through the joint work of progressive physicians and informed lay groups, policies which will produce better quality, distribution and organization of medical services and which can be incorporated in legislation.
>
> "2. The principle of joint participation by the profession and the public, in planning and administering professional services, must be established for the sake of both groups. In its demand for "control," organized medicine has failed to discriminate between professional procedures, in which the physician is the only expert, and the policies and administration of medical services, in which many other groups besides the medical profession are both concerned and informed. Continued failure to recognize this distinction will jeopardize medicine's control of even its proper area. A continuing national agency including representatives of lay and professional groups is needed to dramatize and effectuate the principle of joint participation. The present need of postwar planning gives such a proposal timeliness.
>
> "3. The third task is even more urgent: the creation of correct popular understanding of broad issues and the destruction of misstatements. For this an aggressive agency is now needed, working in coöperation with organized labor and other bodies."

In regard to a challenge in the above editorial, the Speaker of the House of Delegates of the American Medical Association, Dr. H. H. Shoulders of Tennessee, in his address given on June 12th, stated:

> "I have never thought it appropriate for one in my position to speak on any question which may become an issue before the House. However, I don't think it will be a violation of such a policy for me to make brief reference to an alleged 'challenge' to the profession (*Medical Care*, February, 1944, p. 11). In reality the 'challenge' is to this House of Delegates, because you are the only representative body of doctors in position to answer any such challenge to the profession.
>
> "The so-called challenge is made by an active proponent of radical change in our American system of medical practice. It is to the effect that the very high quality of medical care which all admit is being received by the soldiers and sailors of our armed forces everywhere is proof that such a regimented system of medical care should be adopted and enforced by the federal government for all the people. It is not at all surprising that such a suggestion should be made from the source it comes. Nor is it surprising at all that the author failed to mention several features of the military system. He did not mention the fact that in this system the patients and the doctors *are both regimented*. He did not mention that patients in this instance are tagged and sent or ordered to a certain institution for service, that they are required to accept whatever service is provided and that they continue to be under military discipline even as patients. The author of this challenge attempts to carry forward the obvious deception that the medical profession can be regimented without at the same time regimenting the patients also. He forgets that you have stood for freedom of the patient first, not just for the freedom of the doctor. He forgets, or at least does not mention the fact, that soldiers both medical and combatant have sacrificed their personal freedom for the moment, as they are willing to sacrifice their lives, for the purpose of winning a war to make freedom secure; that they do not make this sacrifice merely to demonstrate what, to some, may appear to be an ideal way of life.
>
> "Most important of all, he who would apply a military regimen to civilian life forgets that the judgments and the skill brought to bear on the medical needs of our military forces are fundamentally the product of our civilian system of medical training and practice, in the development of which the policies adopted by this House of Delegates are entitled to no small measure of credit. He does not mention the numerical ratio between doctors and patients in the Army, nor does he make any reference at all to the cost of medical care under military administration.
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> "I call attention to this challenge for the purpose only of emphasizing again that the proponents of radical change are as clever, persistent and deceptive as they are fundamentally unsound."

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* For editorial comment, see page 2.

Northern California Union Health Committee

The "Northern California Health Committee" is a committee organized to work with every labor, health and medical group in this area to better the health and safety of organized workers in Northern California.

The Northern California Union Health Committee will act as a clearing house for material and information about health and health activities; through union committees already in existence will integrate and make available to unions the work of large lay organizations and medical agencies; will release weekly health articles to union publications reaching 200,000 people; will facilitate the work of labor with management and government agencies upon educational projects such as nutrition, communicable disease, and industrial health; will act as an over-all service committee in matters of health and safety for union men and women.

The address of the organization is: 57 Post Street, Rooms 707-708, San Francisco 4, California, Telephone GArfield 4793.

The Northern California Union Health Committee shall put into action the resolutions adopted by the Bay Area Union Health Conference held January 16th, 1944, at the Civic Auditorium in San Francisco. These resolutions are the product of the united effort of an assembly of AFL, CIO, Railway Brotherhood, and independent union delegates with representatives of public health agencies and unofficial agencies such as the Tuberculosis Association, Heart Association, Nutrition Council and Social Hygiene Association.

* * *

Resolutions on Public Health

Public health means protecting the health of all the people in an ever-expanding program.

1. All unions shall initiate and sponsor mass x-ray surveys of tuberculosis and mass examination for venereal disease.

2. All unions shall unite behind an amendment to the present state residence statute, so that tuberculosis care is made available to every resident.

3. All unions shall work with health departments in the improvement of services and facilities, and urge the appropriation of adequate funds for public health services.

4. All unions shall press for adequate provision for health education in the curricula of public schools. All unions shall institute a program of health education for members and their families, utilizing the materials and services which are available from established public and private agencies.

5. A labor advisory committee consisting of one representative each from the AFL, CIO and Railway Brotherhoods shall be appointed by the State Department of Public Health, by each City and County Department of Public Health and by various health associations such as the Tuberculosis Association, the Social Hygiene Association, etc. The purpose of these advisory committees shall be to facilitate union-government-professional-public coöperation in the public health field.

6. Unions shall petition the city government of Richmond and El Cerrito to institute adequate public health programs under the direction of competent full-time health officers.

Resolutions on Nutrition

1. Unions shall see that adequate supervision is afforded in-plant feeding. Unions shall recommend that the State Bureau of Food and Drug Inspection and local Health Departments appoint sufficient personnel to insure proper inspection of such facilities.

2. Unions shall coöperate with local and state organizations in an effort to bring an educational nutrition program into the homes of working people.

3. The Union Health Committee shall establish a subcommittee on Nutrition and Industrial feeding problems.

Resolutions on Health Insurance

1. The Northern California Union Health Committee shall study all health plans in existence with emphasis upon the California Physicians' Service and Kaiser Plans, for the purpose of working out proposals for immediate health care to be submitted to the unions for their consideration and participation, and shall endorse the California Physicians' Service and Kaiser Plans as worthwhile projects.

2. In communities like the Harbor Gates Area in Richmond where there are no existing facilities, the United States Public Health Service shall be petitioned to take charge during the emergency.

3. The Northern California Union Health Committee shall endorse and work for the passage of the Wagner-Murray-Dingell Bill.

Resolutions on Industrial Health

1. Unions shall designate members in each plant to serve as union safety committee members and also set up union safety committees.

2. Union safety committees in each plant shall form a plant-wide safety committee on which representatives of management and management safety departments shall be asked to serve. Such committees shall seek causes of accidents and ask for action to eliminate these causes and to enforce safety procedures.

3. Plant-wide safety committees shall issue educational material signed by both labor and management.

4. Business representatives from all local unions participating in the Committee shall work with accident and health bureaus.

5. The Northern California Union Health Committee shall investigate the problem of pre-placement medical examination by labor and management in industry.

6. Unions shall seek more strict enforcement of already existing industrial health laws, and an increased State budget for this purpose.

7. Unions shall set up committees to aid in finance and manpower on industrial health and accident problems.

* * *

The importance of medical care in the lives of the people has been clearly defined in the second Bill of Rights as enunciated in President Roosevelt's statement to Congress. The majority of American people have never received adequate medical care. Poor distribution of physicians before the war left entire areas in this country medically impoverished. Four years of war-time stress under such conditions place the home front in grave danger.

The Northern California Union Health Committee shall prove, as does the existence of other such groups recently sponsored by labor, that the working people of America shall share the leadership in planning health programs for our country, in war and in peace.

AFL Medical Center Opens in Los Angeles

The beginning of one of Los Angeles' most modern and efficient medical services took place about May 1, when the Union Medical Foundation of the American Federation of Labor opened its doors at 609 South Grand Avenue.

Devoted entirely to the needs of all American Federation of Labor members, and to the maternity cases of the wives of servicemen now on military duty and to those whose husbands have been honorably discharged, the service is the result of Organized Labor's coöperation with the Union Labor Service Department.

Union Medical Foundation has been approved by the Los Angeles Central Labor Council and will be open 24 hours a day, seven days a week, after the first three months.

Purpose of Foundation

The plan was outlined by the Central Labor Council several weeks ago by Lloyd Mashburn. Its objectives are:

1. To provide complete facilities and an adequate staff in Los Angeles for the prompt and competent care of injured workmen and for the maternity cases of wives of United States servicemen now on military duty as well as those whose husbands have been honorably discharged from military duty. In addition to being extended to the wives of all servicemen, the maternity care is also offered to the wives of all AFL members, and at the same rate of $50.

2. To safeguard the workman from total or permanent disability.

3. To reduce to as great an extent as possible the number of disability claims resulting from industrial accidents or diseases.

Primary aim is to render prompt and efficient medical aid to the injured or diseased workman, aid that is vital not only to health and life itself, but aid which is an economic necessity for the insurance carrier whose claims mount in direct ratio to the loss of time, and ability, of the insured.

Under present conditions, workmen are frequently neglected while the status of their injuries as industrial or non-industrial accidents or diseases is being determined by the California State Industrial Commission. In many cases, the workmen, having both insufficient funds and no real understanding of his injuries, fails to obtain proper medical attention pending a decision of the authorities.

Goal of the Foundation is to maintain the finest medical service for its patients, and by its efficient care to return them to work with a minimum loss of time and a maximum of physical well-being.

The Plan

The Union Medical Foundation of the AFL will provide:

1. Medical and surgical diagnosis and treatment of all industrial accident injuries and diseases.

2. Complete and competent medical care of all AFL members and servicemen's wives when needing maternity care.

3. Hospitalization for industrial cases.

4. All diagnostic laboratory tests.

5. X-ray examinations.

Management of the Foundation will be vested in a consulting committee composed of staff physicians and members of the American Federation of Labor, who will meet regularly at the Foundation.

While the main Foundation will be located at 609 South Grand Avenue, it is proposed that branch offices be situated in the metropolitan areas which are more adjacent to industrial activities.—Los Angeles *Citizen.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session will be held in New York City.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday program at 10.15 a. m., under the title, "Your Doctor and You."

In July KFAC will present these broadcasts on the dates of July 1, 8, 15, 22, and 29.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Departments of the United States Army and the United States Navy, are on the air each Saturday at 2 p. m., Pacific War Time. Series commenced on January 8, 1944, will run for twenty-six weeks.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Oleanders (Galveston orchids) to:* F. H. Redewill. A. L. Rose & Mead Johnson & Co. for arranging the 7th annual exhibition of the American Physicians Art Association at the Stevens Hotel, Chicago, for the AMA meeting June 12-16; the AMA section officers for a swell program (JAMA, 125: 40-70, May 6, 1944); E. P. Mumford and J. L. Mohr of Stanford for their forthcoming free *Manual on Distribution of Communicable Diseases and Their Carriers in the Pacific Islands;* I. Chavez on his fine Instituto Nacional de Cardiologia in Mexico City, with the great Diega Rivera frescos on the history of cardiology, and to R. Pratt, T. C. Daniels, J. J. Eiler, J. B. Gunnison, W. B. Kumler, J. F. Oneto, L. A. Strait, H. A. Spoehr & Co. for finding antibiotic "chlorellin" to chlorella algae which can be so easily grown (*Science,* 99: 351, Apr. 28, 1944). Also to J. Mitchell for a worthy essay on rats and plague in the April 28th *New Yorker.* And to Alien Property Custodian for issuing first list of available foreign titles from Edwards Bros., lithoprinters at Ann Arbor.

2. *Cancer:* Should be "cancers,"—M. Shimin says we should differentiate cancers and not speak of "cancer" as a single disease. L. Gross raises question of cancers being biologically communicable, but omits reference to J. Beard's collected papers issued by Chatto & Windus in London in 1911 (*Cancer Res.,* 4: 293, 1944). D. Burk & Co. continue studies on production in malignancy *in vitro,* and discuss blood proteose in cancers, *J. Nat. Cancer Inst.,* 4:363, 417, 1944).

3. *Chemotherapy:* A. Albert reviews cationic chemotherapy with reference to acridines (*Med. J. Australia,* 1:245, March 18, 1944). Resistance of organisms to sulfonamides is surveyed by W. T. Goodale and L. Schwab, and also by W. W. Spink and J. J. Vivino (*J. Clin. Invest.,* 23:217, 267, 1944). Winthrop issues second series of its annotated bibliography on penicillin.

4. *Federated Proceedings:* K. H. Beyer and A. R. Latven say succinate shortens barbital narcosis (*Fed. Proc.,* 3:4, 1944). A. H. Brown and R. E. Gosselin confirm reduction of water loss by shade and clothes wetting (*ibid.,* 5). V. Johnson & Co. show that high fat diet taxes bone marrow in recovery of hemorrhagic anemia (p. 8). A Grollman finds that oxidized marine oils lower experimental hypertension (p. 15). J. T. Hart and W. A. Selle find that urea peroxide contracts smooth muscle (p. 17). H. A. Haterius and E. Glassco confirm M. Prinzmetal that liver extract protects against fatal burn shock. A. M. Hughs notes that thiouracil protects against high altitude anoxia and CO poisoning, but not against cyanide (p. 21). M. B. Visscher & Co. report that high oxygen intake increases metabolism and reduces shivering (p. 26). S. O. Levninson & Co. propose standardized method to produce shock for plasma substitute assay (p. 29). N. S. Maluf says negative intrapleural pressure is result of retractile tension of lungs (p. 31). E. Ogden and C. F. Dalziel analyze sensations during passage of constant galvanic current (p. 35). R. K. Richars and G. M. Everett describe analgesic and anticonvulsant action of 3,5,5-trimethyloxalidine-2,4-dione

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† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Dr. Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

(tridione) (p. 39). G. E. Wakerlin & Co. confirm value of renal extracts in treating spontaneous hypertension (in dogs) (p. 50). The Fraenkel-Conrats discuss pituitary control of blood insulin level (p. 57). H. H. Anderson and H. Y. Soong are pessimistic on chemotherapy of experimental leishmaniasis (p. 64). J. H. Draize describes methods for studying skin absorption (p. 69.) J. H. Finnegan notes anticonvulsant action of diethylsuccinyl urea (p. 72). C. A. Handley & Co. find amphetamine best antagonist to morphine (p. 75). J. L. Morrision notes choleretic action of halogenated fatty acids (p. 83). A. A. Nelson notes hepatic injury from atabrine (p. 91).

5. *Etc.:* Marsh's notes on management of civilian war gas injury (*Ann. Int. Med.* 30:376, 1944). H. S. Mayerson discusses physiology of orthostatic circulatory failure (*Amer. J. Physiol.,* 141:227, 1944), now treated clinically by R. Gregory with desoxycorticosterone and sodium chloride. A. Hemingway analyses cold sweating in motion sickness (*ibid.,* p. 172); C. Entenman & Co. note effectiveness of lipocaic in preventing fatty livers (*ibid.,* p. 221). H. S. Bennett & Co. describe effect of anesthetics on normal and shock circulation (*J. Clin. Invest.,* 23:181, 1944).

Telephone Listings of Physicians in Los Angeles Telephone Directory.—"The Bulletin" of the Los Angeles County Medical Association, in its issue of June 15, gives the following information:

A report for the Committee on Telephone Directories, Listings and Service was presented by Doctor Wilbur Bailey, member of the Committee, who introduced Mr. Harold E. Dryden, business manager of the classified telephone directory. A change in the listing of members of the Association in the classified directory was discussed by Mr. Dryden, by Doctor William H. Daniel, chairman of the Committee, and by members of the Council.

The Committee recommended approval of the telephone company's proposal of a master list entitled "Physicians and Surgeons, M.D." as now carried, with the addition that in this master list, in an appropriate alphabetical location, members so desiring may be listed under "Los Angeles County Medical Association" by the payment of a fee designated by the telephone company, this fee to be seventy-five cents per month per member. Upon motion by Doctor Tollefson, seconded by Doctor Crowe, the Council approved this proposed listing.

National Foundation for Infantile Paralysis.—To provide men and women professionally trained in public health work who will aid the nation's army of polio fighters, The National Foundation for Infantile Paralysis has set aside the sum of $50,000 for fellowships in health education.

Under this program, which has been developed in coöperation with the U. S. Public Health Service, qualified men of certain Selective Service classifications, as well as qualified women, will go into training starting this fall.

Basil O'Connor, president of the National Foundation, explained that in coördinating the community's resources of official and voluntary agencies the services of competent health educators would greatly facilitate handling polio outbreaks and the long-continued after-care of infantile paralysis patients. The National Foundation feels that sponsoring these fellowships will therefore result in a public service of far-reaching benefit, he added.

In coöperating with the National Foundation, Surgeon General Thomas Parran, of the U. S. Public Health Service, said: "The success of well-planned state and local health education programs has amply demonstrated the value of trained personnel having a thorough knowledge of both public health and education. In recent years, the rapid expansion of health education throughout the nation has created a demand for qualified workers that far outstrips the available supply."

Candidates for health education fellowships will be selected by an advisory committee of the U. S. Public Health Service, and those accepted will be assigned to schools of public health at Yale University, the University of Michigan and the University of North Carolina.

A Bachelor of Science Degree, or its equivalent from a recognized college or university, is an essential qualification for one of these fellowships leading to the Master of Science degree in public health. This postgraduate training will consist of nine months' academic work, followed by three months of supervised field experience.

Women between the ages of nineteen and forty who have the above educational qualifications and who are citizens of the United States are eligible. Men who are United States citizens over thirty years of age also may apply, and the War Manpower Commission has declared Selective Service registrants in 4F and 1AL classifications as eligible for health education fellowships.

A fellowship in health education covers a stipend to the trainee of $100 monthly for twelve months; tuition and university fees to the school; and expenses for field service. Applications are obtainable from the Office of the Surgeon General, U. S. Public Health Service, Washington (14), D. C. Applications must be accompanied by a transcript of college credits and a small photograph, and must be in the Office of the Surgeon General not later than August 15, 1944.

Association of Military Surgeons of the United States.—The program for the Annual Meeting of the Association of Military Surgeons of the United States to be held at the Pennsylvania Hotel, New York City, November 2-4, inclusive, is being rapidly completed. In addition to addresses by the Surgeons General of the Army, Navy, and U. S. Public Health Service and by other distinguished guests, there will be formal papers, panel discussions and scientific and technical exhibits on the latest advances in military medicine.

For additional information, address: Chairman, Convention and Program Committees, Col. C. M. Walson, (MC), U. S. Army, Headquarters Second Service Command, Governors Island 4, New York.

The Dionne Quintuplets Are Ten.—When the famous Canadian quintuplets celebrated their tenth birthday on May 28th, the happy event not only marked a milestone in the lives of these five girls, but it also added a page to medical history. For, so far as authentic records show, never before have all five babies born at one time survived for a decade; in fact, except for the quintuplets reported born in Argentina last July, never before have all five babies born at one confinement been known to live more than a short time after birth.

The Dionne quintuplets are "identical," that is, all five developed from a single ovum—another factor which might have operated against their survival. There is statistical evidence to show that identical children do not have as good a chance as fraternal children (plural births where each child develops from a separate ovum) to be born alive and to survive the hazardous first month of life. Data pertaining to the country as a whole for the period 1933-1941 show, for example, that among twins of different sexes—fraternal twins, in other words—out of every 1,000 babies born, 941 are born alive; among twins of like sex, which include both identical and fraternal offspring, the figure is 919 per 1000. The evidence is even more striking among triplets. In cases where both sexes are represented, there are 891 live births per 1,000 babies born; where the triplets are all of one sex, the figure is 840.

Coventry Blitz Data.—Dr. Arthur Massey, medical officer of health for the City of Coventry, England, was one of the principal speakers at the Southern California Public Health Association conference at the Civic Auditorium in Pasadena June 1 and 2.

Dr. Massey was invited by the American Public Health Association to speak in the United States on recent developments in British health services, health education and various other aspects of British public health practice.

During the great Coventry blitz Dr. Massey was in charge of the emergency medical services section of the Coventry Civilian Defense plan. He succeeded in keeping the bombing casualties relatively small, and the city free from epidemics.

Dr. Massey has held his present post since 1930. His responsibilities include supervision of hospitals, clinics, food and water supplies, health education and housing hygiene in the area. He is also a member of numerous medical committees, including the Medical Planning Commission, the Central Council for Health Education, and he is chairman of the Coventry division of the British Medical Association.

Dr. Massey, 50, graduated with honors from the University of Leeds in 1920, after having served as an officer of the Royal Artillery in India during World War I. He obtained a diploma in public health in 1921, and one in public administration at the University of London in 1932.

In 1941, Dr. Massey was created a Commander of the Order of the British Empire. He has published many accounts of his researches in industrial medicine and slum clearance.

At the opening session of the Southern California Public Health Association, the afternoon of June 1, Dr. Massey spoke on "New Trends in Public Health," a subject discussed by Dr. Hubert O. Swarthout, health officer of Los Angeles County.

Licenses of New York Physicians Suspended.—The licenses to handle cases under the Workmen's Compensation Act of 272 physicians were suspended by the New York industrial commissioner, June 4, under accusation of a "kick-back" racket. A legislative committee revealed widespread bill padding and "kick back" of fees by specialists, surgical houses and others to whom the physicians had referred injured workmen.

Leading workmen compensation writers on the Pacific Coast report no indication of a similar occurrence here

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American Urological Society.—Dr. Jay J. Crane, assistant clinical professor of urology at the University of Southern California Medical School on June 3 was elected president of the American Urological Society's western section. Dr. Dudley Fagerstrom of San Jose was named vice-president and Dr. Adolph Kutzmann of Los Angeles, secretary-treasurer.

Fighting Tuberculosis in Wartime.—Everyone remembers Sherman's definition, "War is hell." In the first two years after our entry into the war, it has taken a toll of 69,000 of our citizens, either dead or missing. Yet in the same period there were more than one and one-half times as many deaths from tuberculosis in the United States, or 112,000 tuberculosis deaths.

In past wars the tuberculosis death rate has risen. It has also risen in this war in other countries. It seems reasonable to suspect that the increases are due to factors such as crowded living conditions, lessened opportunities for preventing the spread of the disease, long hours and high-pressure work, limited diets, and the temptation for active cases to work when they should be taking treatment recommended by physicians.

Many authorities have recognized the need for increased efforts in combatting tuberculosis in wartime. Health education activities have been expanded. Unprecedented steps have been taken to find early tuberculosis. The Army and Navy x-rays all inductees. Almost 13 per cent of the new cases for 1943 in California were found through the follow-up of the men referred by the State Selective Service. Civilian agencies, including the U. S. Public Health Service and the Tuberculosis Associations, are x-raying hundreds of thousands of industrial employees. But sanitorium and other public health and treatment facilities have not been increased. In some instances their use has actually been decreased.

We were wont to think of tuberculosis as having been pushed down the ladder in causes of death to sixth place. This was true in the United States as a whole in 1942. Let us come closer home and see what happened in California that year.

Tuberculosis was the second cause of death in California for all age groups, 1 to 45 years. For 1 to 4, tuberculosis was exceeded only by pneumonia and influenza (a combined cause of death); for age groups 5 to 14 and 15 to 24, motor vehicle deaths took first place, with deaths from tuberculosis a close second; in the 25 to 44 group, heart disease assumed first place followed closely by tuberculosis. These figures may serve to keep us from becoming satisfied with past accomplishments in reducing the tuberculosis mortality.

National Foundation for Infantile Paralysis.—Twenty-seven grants totaling $1,128,770 for intensifying and broadening the nation-wide fight against infantile paralysis have just been made by The National Foundation for Infantile Paralysis.

The grants, which were made to leading universities, laboratories and other organizations from coast to coast, will strengthen the National Foundation's program of seeking ways and means of alleviating suffering of victims and will press even harder the ceaseless battle to find a preventive or cure for the disease.

Prominent among the grants are three long-term programs, each covering a five-year period. Two of the long-term grants, totaling $495,000, are for the purpose of improving knowledge in the field of physical medicine, which plays a significant rôle in the successful treatment of infantile paralysis.

These two grants provide for the establishment of two "Units for Research in Physiology as Related to Physical Medicine."

The larger of these units will be at the Medical School of the University of Minnesota, Minneapolis, established by the National Foundation grant of $320,000. It was at this university that the original tests of the Kenny method were financed by the National Foundation which has maintained a Kenny training center there since that time.

Under a grant for $175,000, the other unit will be established at Northwestern University Medical School, which was one of the first institutions to adopt a Department of Physical Medicine and to encourage research in this specialty.

The third long-term grant, for $325,000, was made to the University of Michigan School of Public Health at Ann Harbor to finance and operate an expanded virus study unit. This unit represents a direct attack on the cause of the disease since it provides both for virus research and for the training of virologists. Special emphasis will be given to the development of some quick, inexpensive and practical method of identifying the polio virus, which, if accomplished, would greatly forward epidemiological studies of the disease as well as making it possible to obtain fast positive diagnosis.

Meningococcus (Epidemic) Meningitis on the Increase in Los Angeles.—There has been a marked increase in the incidence of meningococcus (epidemic) meningitis throughout the United States during the past two years. Los Angeles has shared in this increase, as evidenced by the following figures: During the years 1939, 1940 and 1941, there were 13, 8, and 11 cases of meningococcus meningitis respectively. During 1942, there were 58 cases. During 1943, 154 cases. To date, during the first five months of 1944, there have been 100 cases and 23 deaths.

The Los Angeles City Health Department has called on all physicians to be on the alert to diagnose this disease in the early stages. When diagnosed early, and treatment is instituted with appropriate sulfa drugs, the mortality is very low. The most characteristic symptom is a petechial rash which occurs in from 50% to 70% of patients. This rash is usually scanty, and must be looked for especially around the wrist and ankles. The petechiæ vary from 1 to 3 millimeters in diameter, range in color from rose to deep red, assume quite irregular sizes, may take on various geometric shapes, and in very severe cases may appear as large purpuric (hemorrhagic) areas. The rash occurs within a few hours of the onset of illness and fades in a few days. Other symptoms such as headache, stiff neck, high fever, drowsiness, pains in the limbs and back, are also common.

The organism causing epidemic meningitis is the meningococcus. This organism is easily transmitted from individual to individual by means of minute droplets in the exhaled breath; by direct contact such as kissing; and by indirect contact such as contaminated eating utensils. It is definitely known that the majority of people exposed to a case of meningococcus meningitis will harbor the organism in their throats without becoming ill, and disseminate the organism in the community just as much as would an actual case. The Health Department recommends, therefore, that all contacts of cases of meningococcus meningitis be given small doses of sulfadiazine; i.e., 2 to 3 gm. per day for three days, to eliminate the carrier state.

American Congress of Physical Therapy.—Will hold its twenty-third annual scientific and clinical session September 6, 7, 8 and 9, 1944, inclusive, at the Hotel Statler, Cleveland, Ohio. Physical therapy plays an important part in this work. The annual instruction course will be from 8:00 to 10:30 a. m., and from 1:00 to 2:00 p. m., during the days of September 6, 7 and 8. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. All of these sessions will be open to the members of the regular medical profession and their qualified aids. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, 2, Illinois.

International College of Surgeons.—The Ninth Annual Assembly of the International College of Surgeons will be held on October 3, 4 and 5, 1944, at the Benjamin Franklin Hotel in Philadelphia, Pa. The program will be devoted to War, Rehabilitation and Civilian Surgery.

Minneapolis Public Library Stages a Medical Art Show.—The Minneapolis Public Library staged a unique art show, June 21-July 22, representing the work of leading medical artists the country over. This was part of a program for extending the services of the Public Library to one of the foremost medical centers in the United States, and dramatizing the resources of such departments as the Art, Technical, and Clipping Service.

A display of rare medical books and prints forms an important part of the exhibit. From the library of the Surgeon-General in Washington have come four books showing the earliest examples of anatomical drawings, the datelines varying from 1551 to 1682.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

A.M.A. Loses in Court Test

Chicago, June 20.—(INS.)—The American Medical Association (A.M.A.) was termed today by Circuit Judge Michael Feinberg as an organization which engages in propaganda activities and lobbying.

Judge Feinberg ordered the A.M.A. to pay more than $500,000 in State unemployment compensation and old age benefit levies on salaries paid 653 employes since 1937.

In his ruling, Judge Feinberg upheld an unemployment compensation board of review decision that the A.M.A. is not exclusively an educational or scientific organization, and declared the organization had violated the purposes stated in its charter by engaging in propaganda activities.

The decision ended a suit for a writ of certiorari filed by the A.M.A. last July 29 against the State department of labor, in which it asked to be declared exempt from provisions of the Federal and State Social Security laws. —San Francisco *Examiner,* July 21.

Boston Doctor to Head A.M.A.

Chicago.—(AP.)—Dr. Roger I. Lee of Boston was chosen president-elect of the American Medical Association yesterday. He takes office one year from now.

Dr. Stanley J. Seeger of Texarkana, Texas, was elected vice-president, and Dr. Olin West of Chicago, whom the California delegation tried unsuccessfully this week to have retired, was reëlected secretary. The elections were unanimous.

Dr. Herman L. Kretschmer of Chicago is president for the 1944-45 year. Retiring president is Dr. James E. Paullin of Atlanta, Ga.—Sacramento *Union,* June 17.

Doctors Told Post-War Task

Chicago, June 12.—Dr. James E. Paullin, Atlanta, Ga., president of the American Medical Association, today directed the Association's house of delegates to consider the problems of maintaining medical education during the war and rehabilitation of men discharged from the armed forces.

Dr. Paullin told the delegates at the opening of the A.M.A.'s 94th annual convention that because of a selective service directive prohibiting deferment of premedical students the only persons attending medical schools in 1945 will be physically disqualified men and women.

He suggested the establishment of a central coördinating agency representing all groups active in rehabilitation of persons released from the armed forces to avoid reduplication of effort and overlapping of service.

Dr. Paullin urged the delegates to consider the recommendation of the A.M.A.'s post-war planning committee that a bureau for the better distribution of doctors be established at Chicago to act as a clearing house of information for physicians discharged from the armed forces.

He advocated the establishment of refresher courses for the "20,000 to 25,000 younger physicians now in military service who have never engaged in the private practice of medicine."

More than 20,000 physicians and their families are registered for the five-day convention which occupies five hotels, and more than 300 speakers are scheduled to address the sessions.—San Francisco *News,* June 12.

California Doctors at U. S. Meeting Stage Revolt, Fail

Chicago, June 15.—(AP.)—An attempt by the California delegation to overthrow the present leadership of the American Medical Association failed yesterday by a vote of 144 to 9 in an executive session of the house of delegates, the legislative body of the Association.

The California delegation introduced a resolution to replace Dr. Morris Fishbein as editor of the *Journal of the American Medical Association* and to retire Dr. Olin West, secretary of the Association. Dr. Fishbein, as editor of the journal, is internationally known as spokesman for the Association. Dr. West, as secretary, is the most powerful officer in the affairs of the Association.

Two of the nine votes favoring the resolution were from outside of California.—Oakland *Tribune*, June 15.

Doctors

There is sense in the American Medical Association protest against a selective service ruling which denies deferment to premedical students. The ruling is silly. Of course, the premedicals may be as much as eight years away from practice. But under any program the postwar order is going to need competent medical care for mind and body. If it takes eight years to make a doctor we want no shortcuts. There may be cases where refusal of deferment is justified, but a general order is wrong.—Editorial in San Francisco *Chronicle*, June 8.

You Are Lucky

Industrial News Review: Schemes for the socialization of medicine permit gambling with a large number of votes from people who are of necessity uninformed on the scientific issues involved. Medicine and health should never be a political issue. Medical science and progress know no political limitations.

The American Medical Association will hold its 94th annual session in Chicago this month. The progress made in unregimented American medicine has been phenomenal. Reading over titles of papers to be presented, one is astounded at the number of lifesaving names and medical practices that are now familiar to all citizens, which were never dreamed of a short generation ago.

Yes, indeed, American medicine is not keeping abreast of the times, but ahad of th times in its discoveries and techniques, and in its plans to coöperate in making them available to all the people.

If you live in the United States, or are in its Armed Services, you are lucky, for you have access to the world's best medical resources.—San Gabriel *Sun*, June 8.

Social Security Chief Warns on Deficit Prospect

Washington, May 27.—(UP.)—Chairman Arthur J. Altmeyer of the Social Security Board was revealed today to have warned Congress that the social security fund faces the prospect of an increasing potential deficit the longer an increase in the employer-employee contribution is delayed.

He told a House Appropriations subcommittee that if the nation were required to pay off today the 40,000,000 persons covered by social security, there would be a deficit of $10,000,000,000 in the fund. As it stands, the fund now has a large surplus.

The present 1 per cent rate brings in $1,400,000,000 a year and $186,000,000 will be paid out this year, Altmeyer said, but the pay-out rate and amount will increase as the program gets older.—Los Angeles *Times*, May 28.

Extension of Child Care, U. S. Need, Says Katharine Lenroot

New York, May 24.—The nation's aspirations for its children are "that they should have the chance to become men and women who love freedom, know how to cherish and to share it, and are prepared to defend it," Katherine F. Lenroot told the National Congress of Parents and Teachers today.

But too often "we are prodigal in our dreams" and "miserly in our deeds," Miss Lenroot, chief of the Children's Bureau, U. S. Department of Labor, said. She listed adequate medical care and housing, and a means of dissolving racial tensions as among the necessities for children in the post-war world.

Experience in the administration of maternity and infant care for servicemen's families, she said, "will help us to see how we can make sure, through Federal and state coöperation with doctors and parents, that never again will 10 per cent of the births have to be without any medical care."

Similarly, experiences with wartime housing projects may paint the way to "good housing for every one . . . after the war," Miss Lenroot said.

A million children now are receiving cash benefits under provisions of the social security laws, Mrs. Ellen S. Woodward, member of the Social Security Board, told the conference, "but the programs do not go far enough."

Mrs. Woodward urged an extension of Federal old-age and survivors insurance to all workers now excluded; provision of monthly cash benefits for permanently disabled workers; the gearing of unemployment benefits to the number of dependents rather than only to earnings; and the adjustment of Federal contributions to the relative ability of each state to care for its needy, "to assure to every family a continuing income whenever regular income is cut off by forces beyond the individual's control."—San Francisco *News*, May 24.

Super Super Specious

For an example of the super specious argument listen to Chairman Arthur J. Altmeyer of the Social Security Board testifying before a House committee. He said that if the nation were required today to pay off the 40,000,000 persons covered by Social Security there would be a ten billion dollar deficit in the fund.

Quite so, but if Chairman Altmeyer will produce a process by which the years can be telescoped into a second so that all these 40,000,000 will reach the age of 65 today we will eat the deficit, whether it is in greenbacks, gold or wampum.

Altmeyer sets up a case that can't happen for the simple reason that most of these 40,000,000 won't be 65 and asking payment until they have lived out 65 years.

Bureau chiefs lie awake nights thinking up arguments to aggrandize their agencies and get more money, but never before has one achieved so marvelous a brain paroxysm as this.

The simple fact is, as Altmeyer admits, that the fund now has a large surplus. It can take care of the demands of its clients as they come along in the natural course of time. That is all the reason necessary for refusing Altmeyer the boost he seeks in the Social Security tax.

Altmeyer and the Administration want this increase not for any need of the Social Security fund, but to furnish more money for general Government spending. Their scheme is just a tax under a false name.—Editorial in San Francisco *Chronicle*, May 30.

MEDICAL EPONYM

The Cushing Suture

The Cushing intestinal suture is often wrongly attributed to Dr. Harvey Cushing. The description of this suture was written by Dr. Hayward W. Cushing (1854-1934) and appears on page 83 of *Medical and Surgical Reports of the City Hospital* (Boston, 1889). The article is entitled "'The Right Angle' Continuous Intestinal Suture." Dr. Cushing was one of the members of the surgical staff of the Boston City Hospital, headed at that time by Dr. David W. Cheever. After discussing and classifying intestinal sutures then in use, he describes the new suture as follows:

"A short experience with the above-mentioned types demonstrates that the 'Continuous' sutures have a great advantage in regard to the ease and rapidity with which they can be inserted. The time spent in knotting a fine wet thread, with fingers sticky with blood, in an intestine which is more difficult to handle than a wet rag, is surprisingly long. . . .

"A resected intestine is united by the suture . . . as follows: It is begun at one side of the mesenteric attachment by an inverted Lembert suture, which is tied, and the free end left pendent from the knot. The resected edges are now united by the 'Right Angle' suture . . . commencing at the point of union already made . . . and continued along parallel to the resected edges of the gut, till the free end, at the point of commencement, is reached."—F. D. M., in *New England Journal of Medicine*.

Learning without thought is labor lost. Thought without learning is intellectual death.—Confucious.

MEDICAL JURISPRUDENCE†

Malpractice: Sufficiency of Evidence

In *Dean v. Dyer*, 64A.C.A.771 decided May 31, 1944, by the California District Court of Appeal, the facts were these:

The defendant physician and surgeon specialized in treatment of the eye. He removed a cataract from the plaintiff's right eye, the operation being apparently successful. After his discharge from the hospital, the plaintiff returned to the defendant's office for an inspection, at which time the defendant removed the bandage and placed some drops in the plaintiff's eye. Immediately thereafter, the plaintiff testified that his eye burned intensely and continued to do so on his way home. Shortly after plaintiff arrived home, the defendant physician and surgeon arrived at the house and according to the plaintiff's testimony said, "Something terrible has happened." He then further treated the plaintiff's eye. At the time of the trial the plaintiff was blind in one eye and claimed that the blindness resulted from the defendant physician's negligently putting some caustic or corrosive substance in plaintiff's eye, thereby destroying the sight. The defendant physician contended, on the contrary, that when plaintiff visited his office, he found a deep infection in the eye and had applied a solution of atropine. There was also testimony by the plaintiff, his wife, and a friend that the eye had apparently been in good condition after the operation and at the time plaintiff visited the defendant's office.

The court ruled that in an action for malpractice brought on the theory that in the postoperative treatment of a cataract, defendant negligently put a caustic or corrosive substance into plaintiff's eye with the result that the sight thereof was destroyed no expert evidence was needed to demonstrate that something unusual happened, where plaintiff's eye was in good condition before the substance was placed in it and where immediately afterwards a sudden change took place including loss of sight in the eye. On the trial the defendant was compelled to testify as an expert witness and testified that the atropine, which he had allegedly used, would not have had this affect upon the eye and that even an infection, which he testified was present, would not have had the immediate burning affect with resulting destruction of the eye.

On the basis of this evidence, the court held there was sufficient evidence to support a verdict by the jury in favor of the plaintiff. While expert evidence is usually essential in malpractice cases the court ruled there was no necessity here for expert testimony to establish negligence because it was "common knowledge" that a thing of the kind herein involved does not ordinarily occur in the absence of negligence on the part of the physician. The burden was placed upon the defendant physician to explain the results of his treatment.

LETTERS†

Concerning Gasoline Allowances to Physicians:

(COPY)

San Jose, July 1, 1944.

Mr. P. D. Curtis,
Chairman, West Side Ration Board
Civic Auditorium
San Jose, Calif.

My dear sir:

The Council of the Santa Clara County Medical Society at its recent meeting has had brought to its attention by some of its members that certain members of the profession are unable to secure sufficient gasoline allowances for their necessary requirements.

They have been forced to go through unnecessary procedure in obtaining what they require, and the representatives at your office have been none too courteous on numerous occasions.

Apparently there must be some reason for attempting to force unusual restrictions upon the applicants concerned. You must surely realize that most physicians have had their practices increased by 50-100 per cent since their original applications for mileage allowances due to the fact that from 40-50 per cent of active physicians in this county have entered military service. Some of our members have a practice requiring considerable outside calls while others have mainly hospital and office work only. Hence, their requirements are different. The types of automobile also vary in their gasoline consumption per mile.

The Council of the Santa Clara County Medical Society has taken the necessary action of requesting me to write you and see what steps should be taken to bring about more harmonious conditions between the profession and your West Side Board. We have had no complaints by any of our members concerning the action of the East Side Board.

Please let me have a reply by July 10, 1944, so that I may make a report at the next meeting of the Council of the Santa Clara County Medical Society.

Yours very truly,
FRED W. BORDEN, M.D., *Secretary*
Santa Clara County Medical Society.

Concerning O.P.A. Food Rationing:

(COPY)

San Francisco 4, July 3, 1944.

Fred W. Borden, M.D.
Secretary, Santa Clara County
Medical Society
Sainte Claire Building
San Jose 23, California

Dear Doctor:

I have received a copy of your letter of June 22, 1944, addressed to the War Price and Rationing Board at San Jose. I note there is a dispute between the Santa Clara Medical Society and the Board over the matter of handling additional ration points for patients who need certain foods in quantities greater than can be obtained through the normal allocation of ration points. Of course, under the Acts of Congress creating the Office of Price Administration, the various local rationing boards have more or less arbitrary control over the allocation of additional ration points. The problem was solved in San Francisco at the very outset of rationing when the San Francisco Rationing Board requested the San Francisco County Medical Society to appoint a committee to meet with the Ration Board each week and pass upon all requests for additional points based on medical needs. The committee has functioned to the satisfaction of both the physicians in San Francisco and the Ration Board.

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† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

We would suggest that you urge the San Jose Ration Board to adopt the same procedures and methods as are followed in San Francisco. You might point out to the Board that actions taken by physicians selected by the Santa Clara County Medical Society cannot result in the type of dispute that has arisen under present procedures because if the Medical Society committee turned an applicant down, the Ration Board cannot be blamed.

Accordingly in my opinion, the suggestion contained in the last paragraph of your letter of June, 1944, is an excellent one both for the welfare of the community and the smooth functioning of necessary food rationing procedures.

Very truly yours,
HARTLEY F. PEART.

* * *

(COPY)

June 13, 1944.

Dear Doctor Kress:

Thank you for copies of the correspondence with the Santa Clara County Medical Society relative to additional food rations.

Our only suggestion would be for the Santa Clara Society to appoint a committee to handle requests for extra food rations when ordered by physicians, similar to the committee now functioning in San Francisco. This is a committee of physicians which meets with the Ration Board every week and passes on the requests for additional points. It is a very smooth running committee and I know of no dissatisfaction among our members. We shall be glad to give you further details of our plan if you wish.

Yours sincerely,
CHESTER L. COOLEY, M.D., *Secretary.*

Concerning Demand for an Autopsy Report:

(COPY)

San Francisco 4, June 22, 1944.

Dear Doctor ———————:

We duly received your letter of June 17, 1944, regarding the demand made upon you for a complete copy of an autopsy report covering an autopsy made on a former patient of Dr. ———————.

You ask whether, if the person involved appeared at your office with a court order for a copy of the report, you would be compelled to give it to him personally or whether you could insist that the copy be turned over to the court with a statement as to its technical nature, etc. So far as we know the only manner in which a copy of the report could be obtained by court process would be the issuance of a subpoena duces tecum. This would be an order issued under authority of the court requiring you to attend at a particular time and place and to bring with you a copy of the report in question. You would probably then be given an opportunity to make any explanation.

A subpoena duces tecum of this kind could not be issued unless a court action was commenced, in which the autopsy report might be material evidence. It is unlikely that you will be subjected to court process unless an action is commenced against Dr. ——————— or the ——————— Hospital. . . .

Very truly yours,
HARTLEY F. PEART.

Concerning C.M.A. Membership, When Residence Is Changed:

(COPY)

San Francisco 4, June 15, 1944.

Dear Doctor ———————:

Following our conversation over the phone, I checked up on the by-laws of the California Medical Association.

Section 10 of Chapter II covers the question of membership as affected by transfer of residence. I enclose a copy of this section.

A transferee is eligible to membership in the new county society under the conditions states, "provided, however, that no evidence which would disqualify him for membership exists." The last paragraph covers the position of a member who is not elected to membership in the society of the county to which he goes.

Sincerely,
HARTLEY F. PEART.

Concerning Legal Status of Artificial Insemination:

(COPY)

San Francisco, June 29, 1944.

Dear Doctor ———————:

You have inquired as to the legal status of artificial insemination.

There is practically no advice or information that I can give you in this regard. The only thing that can be said of the legal status of artificial insemination is that as far as we know, there is no law on the subject. We know of no statute in California or any other state which makes such a procedure in any manner contrary to law, and there have been no cases before the courts brought to our attention involving artificial insemination.

Undoubtedly, there are a great number of people who would regard artificial insemination as being socially unsound and even contrary to good morals and the best interests of the community. If it should ever become a common practice, unquestionably there would be legislation on the subject.

One legal question occurs to us which might arise from the use of artificial insemination. That is the question of paternity. At the present time, there is a statute in this State, Civil Code, section 193, which provides that "all children born in wedlock are presumed to be legitimate." Another statute, Code of Civil Procedure, section 1962, provides that "the issue of a wife cohabiting with her husband who is not impotent is indisputably presumed to be legitimate." The possibility of a married woman giving birth to a child after artificial insemination raises the question of whether application would be given to the foregoing sections. Would a husband be presumed to be the father of a child born as a result of artificial insemination and if not who would be regarded as the father? This would be of utmost importance on questions of obligation for support, inheritance, etc.

I regret there is not some specific advice that I can give you.

Very truly yours,
HARTLEY F. PEART.

TWENTY-FIVE YEARS AGO†

EXCERPTS FORM OUR STATE MEDICAL JOURNAL

Vol. XVII, No. 7, July, 1919

EXCERPTS FROM EDITORIAL NOTES

Southern California Medical Society.—The sixtieth regular semi-annual meeting of the Southern California Medical Society, held in the Mission Inn at Riverside, May 14 and 15, 1919, was a banner meeting in attendance. The following program was successfully carried out and held the interest of the delegates until the last paper was read and discussed. . . .

Dr. Walter V. Brem won ringing applause of all the delegates when he stated: "The League for the Conservation of Public Health does not represent any particular section, group, department or clique of the ethical medical profession of California, but all sections, groups and departments in particular. It has no interests but the interests of the medical profession as a whole. We have been supine, afflicted by a great inertia and idly watched incompetents profiteer on the health of the public." . . .

Following the Riverside meeting the officers of the League from Northern California were given a luncheon in the Blue Room of the Los Angeles Athletic Club on May 16. Dr. George H. Kress acted as toastmaster and with felicitous phrasing presented Drs. H. A. L. Ryfkogel, John H. Graves, W. T. McArthur, Granville MacGowan, W. W. Beckett, J. F. Cook and Mr. Celestine J. Sullivan. . . .

Health League of Nations.—Probably no more important subsidiary proposition could be considered in the League of Nations than the establishment of an international agency devoted to the interests of public health. Without health all other international codes fail. Nothing so surely isolates a nation today as illness. Certainly health, in the broadest sense, is one of the most vital and statesmanlike departments which can be incorporated in the League of Nations. . . .

Editorial Comment.—Strange, is it not, that newspapers which parade the prurient episodes of murder, divorce and abortion in heavy type on the first page, should modestly refuse to call syphilis and gonnorrhea by name! Such hypocritical mock modesty is a tremendous handicap in public health education.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "A Review of our Knowledge Concerning the Etiology of Influenza," With notes on the Bacterial Flora of Respiratory Cultures of Influenza Patients in San Francisco, and the Value of Prophylactic Vaccination with B. Influenzae Vaccine," by K. F. Meyer, Assisted by L. E. McRoberts, J. E. Stickel, H. E. Brown, J. Wollenberg.—The request of your Committee, to introduce a symposium on Influenza by a consideration of the etiology of this disease was accepted,

(Continued in Front Advertising Section, on Page 20)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.

Secretary-Treasurer

Board Proceedings

The next oral examination to be conducted by the Board of Medical Examiners is scheduled to be held at the Board office, 907 State Building, Los Angeles, commencing at 10 A.M. August 19, 1944. Applicants, in order to be eligible for admission to this examination, must have their applications on file in the office of the Board at Sacramento at least two weeks before the date of examination.

News

"The Masonic Fraternity will conduct the funeral services Wednesday at 1:30 P.M. in East Lawn Chapel for Dr. Charles Edward Schoff, 59, Sacramento dermatologist, who died yesterday afternoon in his home at 1337 Forty-first Street. He had been ill four years. . . . He served as a member of the State Board of Medical Examiners from 1929 until 1940. . . ." (Sacramento *Bee*, May 29, 1944.)

"After hearing testimony yesterday of Dr. Frank C. Webb, county autopsy surgeon, Municipal Judge Wilber F. Downs ordered Dr. Roland K. Harris, chiropractor, held to answer to the Superior Court on a charge of murder. Webb testified that, in his opinion, the death of Mrs. Julia Zubillage, 26, of Los Angeles, on April 13, was due to bleeding caused by an attempt to perform an illegal operation. Arraignment of Dr. Harris in Superior Court was set for May 22 at 9:30 A.M. He is at liberty on $10,000 bail." (Long Beach *Sun*, May 6, 1944.)

"Clyde Turner late yesterday pleaded not guilty to a charge of posing as a doctor and attempting to treat the sick and afflicted without license, and requested a jury trial. He was released on $100 bail and will be tried May 29th in the court of Justice of the Peace T. F. Lewis. Complaint against Turner was brought by Joseph W. Williams, special Agent of the State Board of Medical Examiners. Williams said Turner was not qualified to practice physical therapy and foot correction nor treat neuritis, nervous disorders or arthritis as he advertised. He said Turner had been issued a city license to practice as a chiropractor, but that he was not eligible to practice as such nor to apply for a license. He said Turner has a diploma from a massage school." (Sacramento *Bee*, May 20, 1944.)

"A self-styled 'soul doctor,' who is accused of defrauding a Fresno family of $285 after offering to cure a member of the family of cancer, today is in jail here charged with grand theft and practicing medicine without a license. She is Mrs. Maria Espinosa, 34, mother of four children, who was arrested in her home in Porterville last night by Deputy Sheriff J. W. Ripperdan and J. W. Williams, a special agent for the State Medical Board. Mrs. Garcia, who had been under treatment in the Fresno County General Hospital for cancer, was discharged from that institution April 10th as incurable. A short time later, Ripperdan declared, Mrs.

(Continued in Back Advertising Section, on Page 36)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members. Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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starring RAYMOND MASSEY

HERE is a Report to the Nation on the wide-spread activities of America's doctors in a world at war, not only on the battlefronts, but on the home front as well. Documentary histories of medical heroism, carefully authenticated and ethically presented, should prove of interest to every physician, military or civilian. The comments or suggestions of the profession are welcomed.

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Clinical Director

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Resident Medical Staff

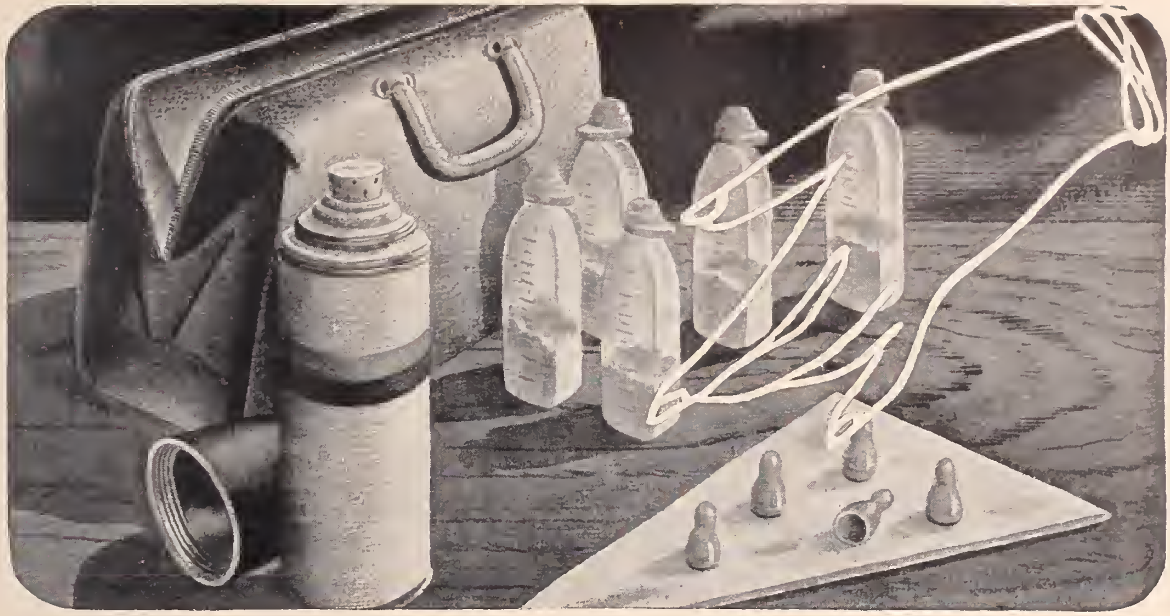
TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 22)

From an Article on "Some Clinical Features of the Present Pandemic of Influenza as Compared with the Pandemic of Thirty Years Ago," by H. Lisser, A.N., M.D., San Francisco.—For every infectious disease, many complications have been described. In pandemics of influenza where such an enormous portion of the population is attacked, opportunity is afforded for a surprisingly large variety of complications. It would be utterly beyond the scope of a 15-minute paper to even itemize these numerous peculiarities of the influenza virus. Even Leichtenstern's masterly monograph of 200 pages in Nothnagel's System of Medicine, which probably is the most comprehensive survey of the great pandemic of 1889-91, barely touches upon a vast number of the influenza complications. The following observations are purely personal ones obtained through experience at the University of California Hospital and in private practice and I shall dwell on only a few features that attracted my attention during this time. . . .

From an Article on "The Treatment of Post-Influenzal Pneumonia in an Army Hospital," by W. W. Roblee, M.D., Riverside.—The influenza epidemic threw a sudden and immense strain upon the Army hospitals. Because of the concentration of men in barracks, the spread of the disease, once it was introduced, was rapid and apparently uncontrollable. It was my fortune to be Chief of Medical Service at the Embarkation Hospital at Newport News, Virginia, at that time. We received patients from our local camps, troop trains, Army transports and the Merchant Marine. The ambulances were

(Continued on Page 28)



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TWENTY-FIVE YEARS AGO

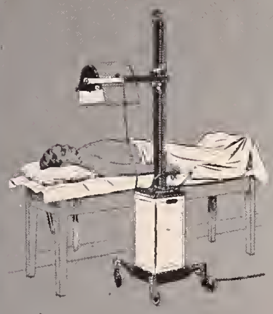
(Continued from Page 26)

busy day and night transporting the sick, and oftimes dying, soldiers to us for care. The epidemic ran its course in six weeks, but those were weeks of strenuous endeavor on the part of the entire hospital staff. During the month from September 20th to October 20th, 623 cases of pneumonia entered our Service. There were 161 deaths, giving us a mortality rate of 25.8 per cent. . . .

From an Article on Pulmonary Conditions Wrongly Diagnosed as Tuberculosis," by William C. Voorsanger, M.D., San Francisco. Discussed by Dr. Hurwitz, Dr. Pottenger, Dr. Shortle, and Dr. Voorsanger.—The studies of recent years upon sputum cultures, particularly the work of Luetscher, the investigation upon the agglutination of various bacilli and particularly the more recent work in government laboratories and army base hospitals, have greatly upset conventional clinical methods of diagnosis, and have made us realize that many pulmonary conditions which, in the past, we looked upon as tuberculosis, were in reality something else. An internist recently made the statement that "tuberculosis men were responsible for diagnosing every pulmonary condition as tuberculosis." This might have been the case at one time, but I feel sure that every real "tuberculosis man" today undiagnoses tuberculosis as much as he diagnoses it. . . .

From an Article on "A Review of the Pneumonia of Last Year," by Albert H. Rowe, M.S., M.D., Oakland.—An unprecedented prevalence of pneumonia has occurred during the last year, associated with the massing together of men for war purposes and the recent epidemics of

(Continued on Page 32)



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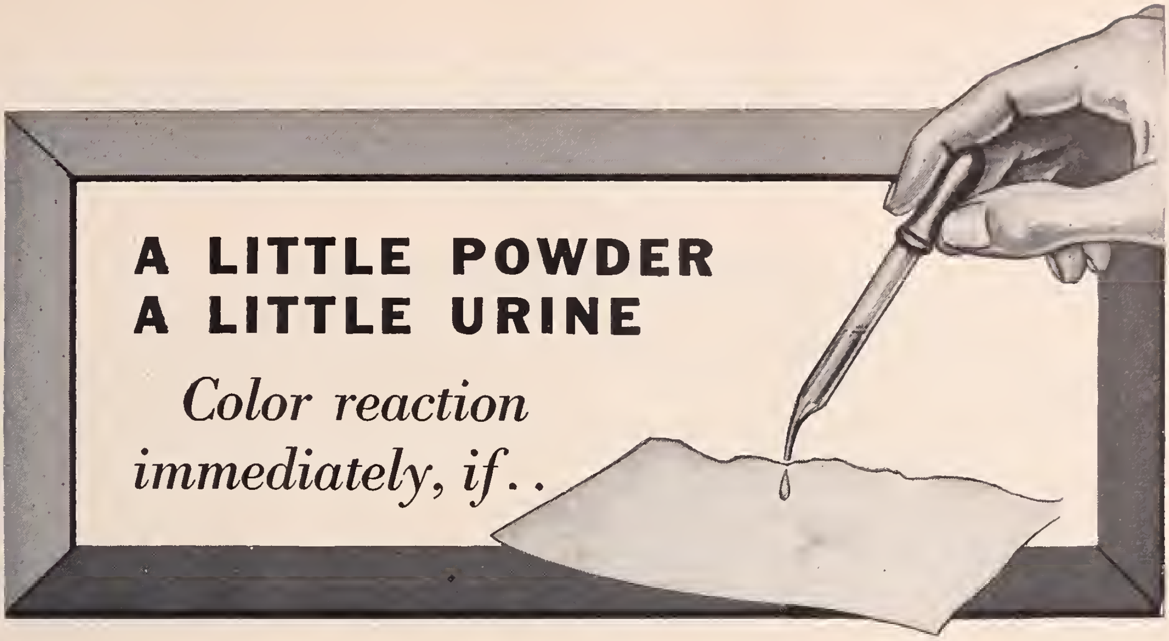
TWENTY-FIVE YEARS AGO

(Continued from Page 28)

influenza, measles, and streptococcal infections. So many articles have been written within the last twelve months dealing with the symptoms and the changes in the routine treatment of these pneumonias and of empyema, that it seems proper at this time to review the situation. . . .

From an Article on "Cystitis as a Diagnostic Fallacy," by George G. Reinle, M.D., and E. Spence DePuy, M.D., Oakland.—Nephritis, Cystitis. Of all the recognizable disease pictures of the urinary system these two as diagnoses rank highest in degree of popularity. So almost exclusively are these terms used that one might question whether other urological conditions are sufficiently well kept in mind, and whether in truth the terms cystitis and nephritis have a definite meaning in the minds of their users. More frequently than should be, are disturbances of the urinary system lacking in definite recognition. It is only within quite recent times, however, that urinary diseases have been studied in terms of living subjects; heretofore they have been classified in accordance with the findings of the mortuary room, and all efforts made to fit the symptoms of the living to the findings of the dead. . . .

If you were to say to me: "What is the first essential for success in war?" I would say the human factor. We must remember it is not the tank, the armored car or the battleship that is going to win this war. It is men, inside them. That is a terribly important thing. Everything hinges on the human factor.—Gen. B. Montgomery.



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A single injection . . . **GLOBIN INSULIN**

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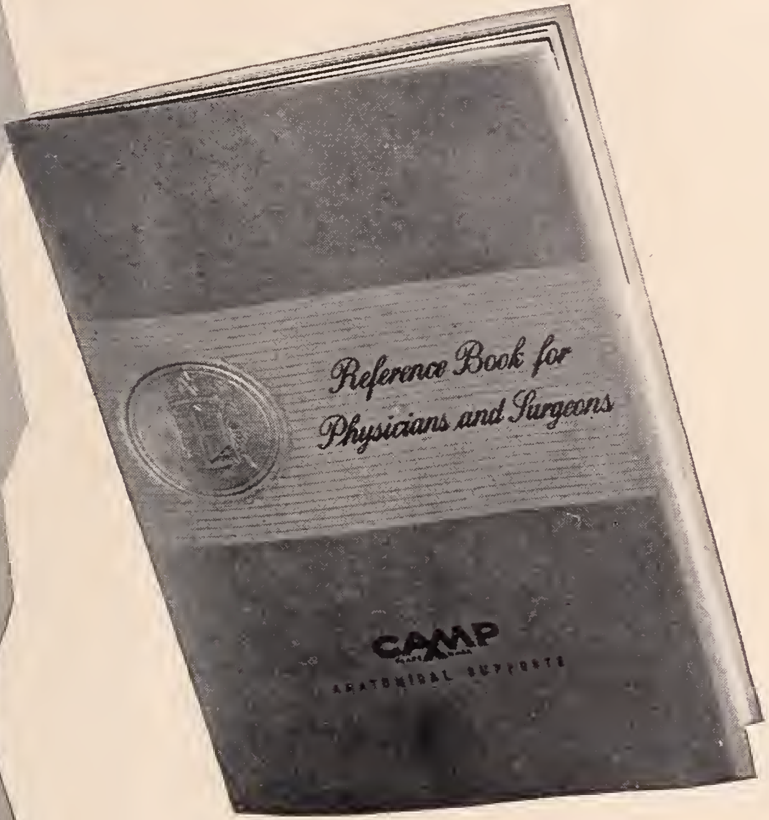

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 48)

Espinosa visited the Garcia home and offered to cure the ailing woman for a fee of $500. The family accepted her offer, and paid to her the $285 she demanded as the down payment on the fee. . . . Mrs. Garcia died on April 26th. . . . " (Fresno *Bee,* May 13, 1944.)

"Pleading guilty to manslaughter charges arising from the death of Mary A. Rubert, 21, of Wilmington, from an illegal operation, Mrs. Minnie M. Middleman has been sentenced to 1 to 10 years in the California Institution for Women at Tehachapi by Superior Judge Leslie E. Still, in Long Beach." (Hollywood *Wilshire Advertiser,* April 27, 1944.)

"Dr. Clyde A. Pierson, San Bernardino osteopath, was sentenced by Judge Charles L. Allison in Superior court yesterday to serve two to five years in San Quentin, after his motion for a new trial on three counts of abortion had been denied. Through counsel, Dr. Pierson served notice of appeal and a stay of execution was granted pending its hearing. Judge Allison increased bail from $2,500 to $10,000, and the osteopath promptly posted the amount in cash." (Ontario *Report,* April 26, 1944.)

"Amos F. Clapp, local chiropractor, accused of murder in the abortion death of Mrs. Doris Mae Branch, asked for more time for plea when arraigned yesterday in Superior Court. Plea was set for Wednesday. Attorney A. H. McConnell, counsel for Clapp, gave notice that he

(Continued on Page 38)

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min G) from natural sources, nutritionally im
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palatable, convenient and economical
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Add milk or water, hot
Serve with milk or
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(Continued from Page 36)

would offer a motion for dismissal at that time. Superior Judge John Gee Clark granted a motion that Clapp, who had been held without bail since his arrest, be admitted to bond, but when the amount was fixed at $30,000, defense counsel pointed out that it would be tantamount to no bail. Judge Clark said that a motion for reduction of bail could be made at the hearing next Wednesday, at which time most of the facts in the case would be presented to the court." (Long Beach *Sun*, Feb. 19, 1944.)

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(Continued on Page 44)

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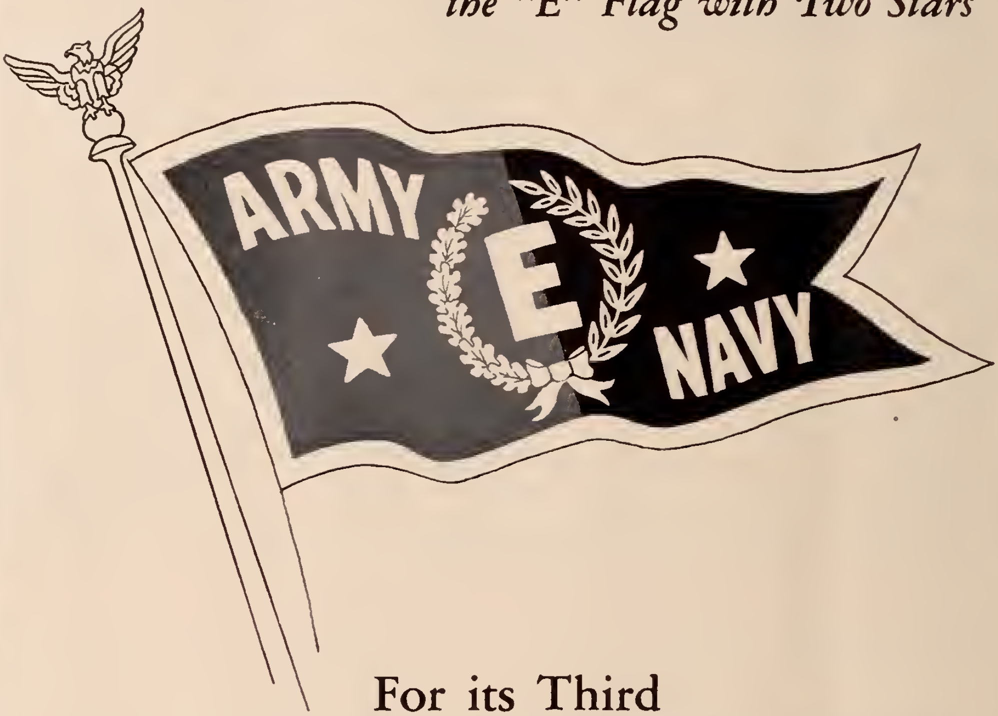

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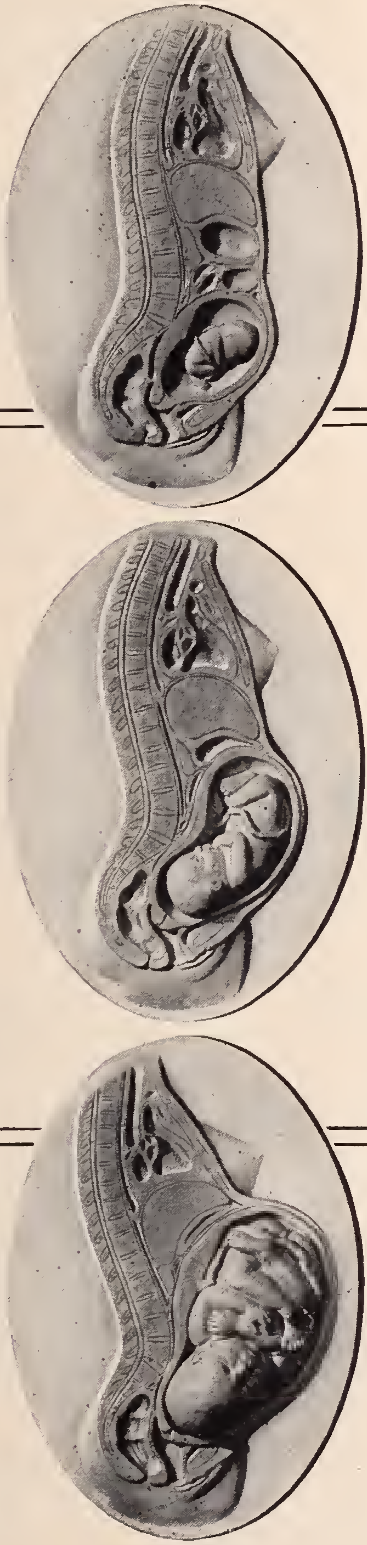

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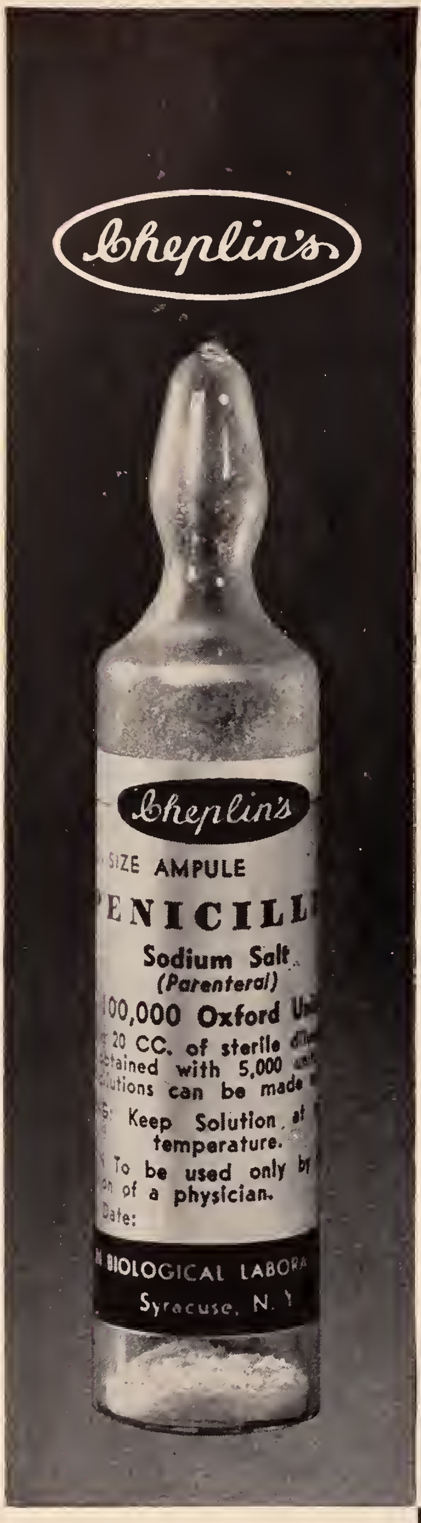
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Fertility in Women. Causes, Diagnosis and Treatment of Impaired Fertility. By Samuel L. Siegler, M.D., F.A.C.S., Attending Obstetrician and Gynecologist, Brooklyn Women's Hospital; Attending Gynecologist, Unity Hospital; Assistant Obstetrician and Gynecologist, Greenpoint Hospital; Attending Sterility Clinic, Greenpoint Hospital; Consultant in Gynecology, Rockaway Beach Hospital; Diplomate American Board of Obstetrics and Gynecology; Fellow New York Academy of Medicine; Member Society for the Study of Internal Secretions. With a Foreword by Robert Latou Dickinson, M.D. Cloth. Price, $4.50. Pp. 450, with 194 illustrations, including 40 subjects in full color on 7 plates. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

Fertility in Men. A Clinical Study of the Causes, Diagnosis, and Treatment of Impaired Fertility in Men. By Robert Sherman Hotchkiss, B.S., M.D., Lieutenant Commander (MC), U.S.N.R. (on active service); Assistant Professor of Urology, New York University Medical College; Instructor in Surgery (Urology), Cornell Medical College; Assistant Visiting Attending Physician, Department of Urology, Bellevue Hospital; Assistant Visiting Attending Physician in Surgery (Urology), New York Hospital; Chief of Urological Clinic, New York University Medical College Clinic. With a Foreword by Nicholson J. Eastman, M.D., Chairman, Editorial Committee, National Committee on Maternal Health; Professor of Obstetrics in Johns Hopkins University; Obstetrician-in-Chief to the Johns Hopkins Hospital. Cloth. Price, $3.50. Pp. 216, with 95 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

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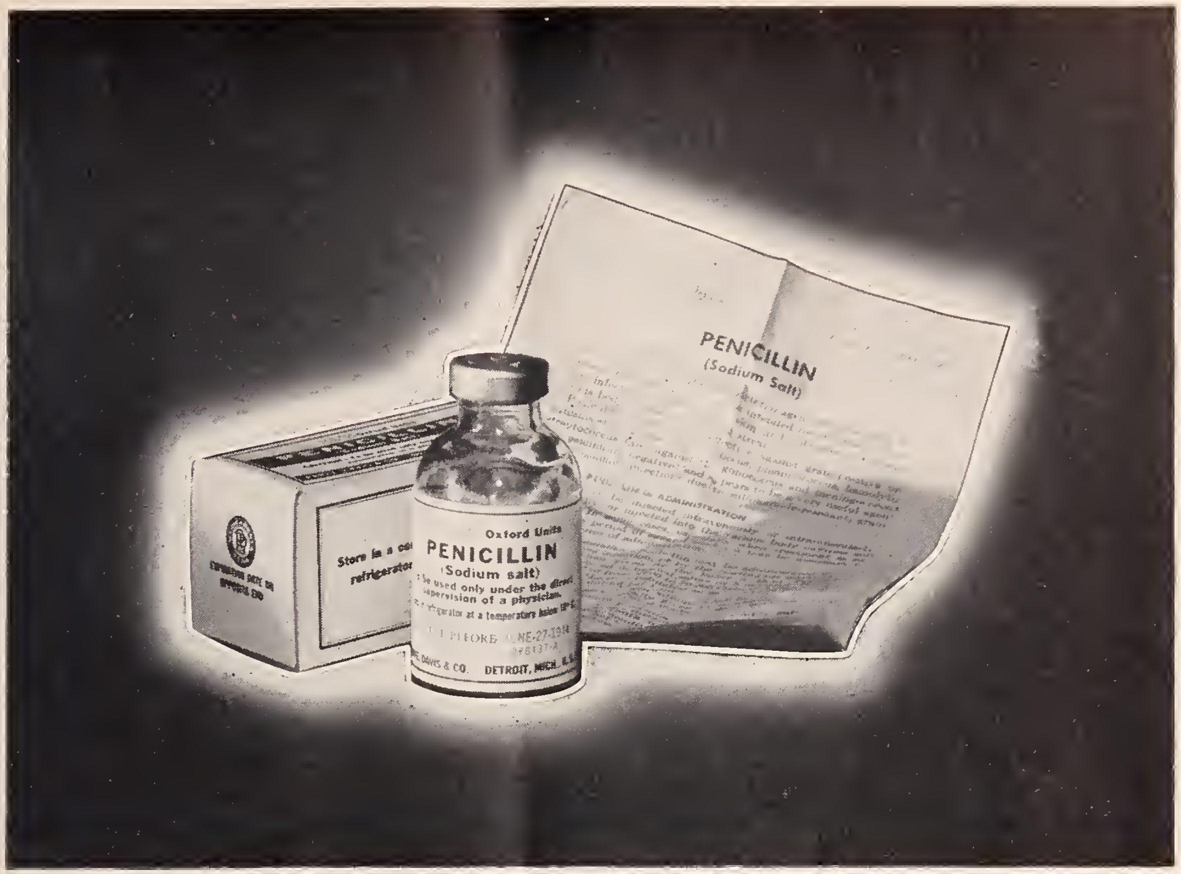
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BOOKS RECEIVED

(Continued from Page 7)

Lippincott's Quick Reference Book for Medicine and Surgery. A Clinical, Diagnositic, and Therapeutic Digest of General Medicine, Surgery, and the Specialties, Compiled Systematically from Modern Literature. By George E. Rehberger, A.B., M.D. Twelfth Edition. Cloth. Price, $15.00. Pp. 1460, illustrated. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

Man Does Not Stand Alone. By A. Cressy Morrison. Cloth. Price, $1.25. Pp. 107. New York, London and Edinburgh: Fleming H. Revell Company, 1944.

Seventy-First Annual Report of the Commissioner of the Michigan Department of Health. For the Fiscal Year ending June 30, 1943. Cloth. Pp. 357. Lansing, Michigan: Franklin DeKleine Company, 1943.

Urological Surgery. By Austin Ingram Dodson, M.D., F.A.C.S., Richmond, Virginia, Professor of Urology, Medical College of Virginia; Urologist to the Hospital Division, Medical College of Virginia; Urologist to Crippled Children's Hospital; Urologist to St. Elizabeth's Hospital; Urologist to St. Luke's Hospital and McGuire Clinic. With contributions by R. A. Berger, M.D., F.A.C.R.; Douglas G. Chapman, M.D., F.A.C.P; Everett Idris Evans, Ph.D., M.D.; Fred M. Hodges, M.D., F.A.C.R.; Major Guy Winston Horsley; Linwood D. Keyser, M.D., F.A.C.S.; and Lawrence O. Snead, M.D., F.A.C.R. Cloth. Price, $10.00. Pp. 768, with 576 illustrations. St. Louis: The C. V. Mosby Company, 1944.

New and Nonofficial Remedies, 1944. Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1944. Issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Cloth. Pp. 778. Chicago, Illinois: American Medical Association, 1944.

(Continued on Page 22)

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Effect of Social Trends on Hospital Service

Social changes now taking place will have a marked effect upon the hospital's responsibility to its community; it is, therefore, timely and necessary that we consider these changes and develop ways and means of meeting them, in the opinion of Frank J. Walter, President of the American Hospital Association and Superintendent, St. Luke's Hospital, Denver, Colorado, writing in a recent issue of "Hospitals," journal of the American Hospital Association.

More and more health service, it is agreed, will be expected from the hospital, Mr. Walter indicates, expressing the belief that hospitals can control their own destiny—at least to the extent of determining how they will meet the challenge of continuous social evolution.

"In keeping with the deeply significant social advances that have been made during the past decade, the American Hospital Association must initiate a program of profound implications for the future of hospital care in America," according to the association president. "This program is devoted to the expansion, development, and coördination of hospital care of high quality, making it available to all persons."

An adequate program of education for nurses and physicians is essential to an enlightened and advanced health program he continues, and education of hospital personnel will result in improved hospital care.

The hospital should coöperate with the medical profession in inaugurating a program of prevention of disease in the community, he says, and it should assume more responsibility in the care of ambulatory patients.

Returning servicemen will bring back memories of the benefits of modern hospitalization on the battle front, and will demand such service for themselves and their families; those engaged in war industries have learned the economic value of health conservation and will continue to demand it. Those who have experienced benefits of the Blue Cross Plans will not be content without this protection, and all these groups will not be satisfied with only bed care in hospitals, but will demand all the late therapeutic and diagnostic facilities which are to be found in modern hospitals.

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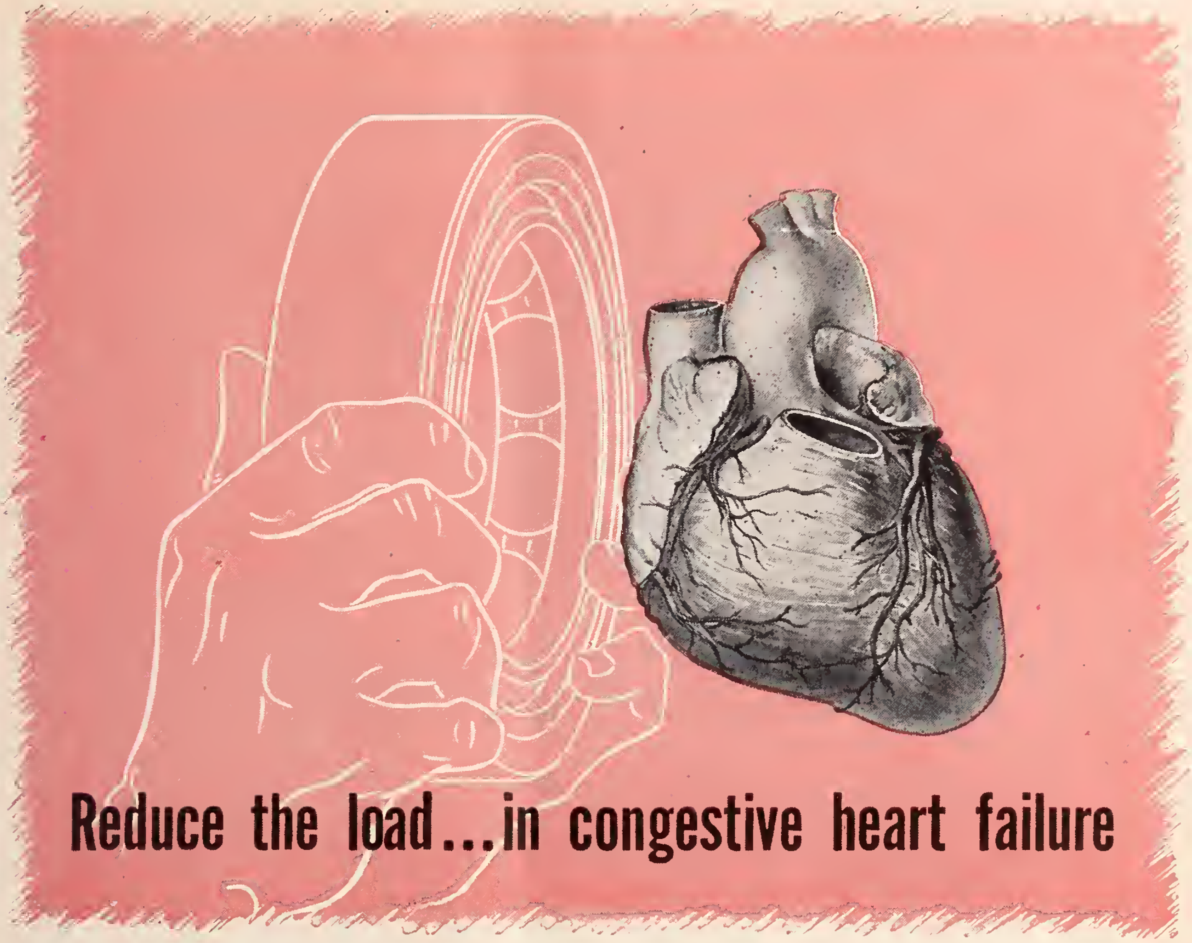
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Today, *Penicillin* Schenley is augmenting the nation's supply of this valuable antibacterial agent. Our goal in these efforts is to aid in furnishing sufficient *Penicillin* to fill the fullest needs of both military and civilian medicine.

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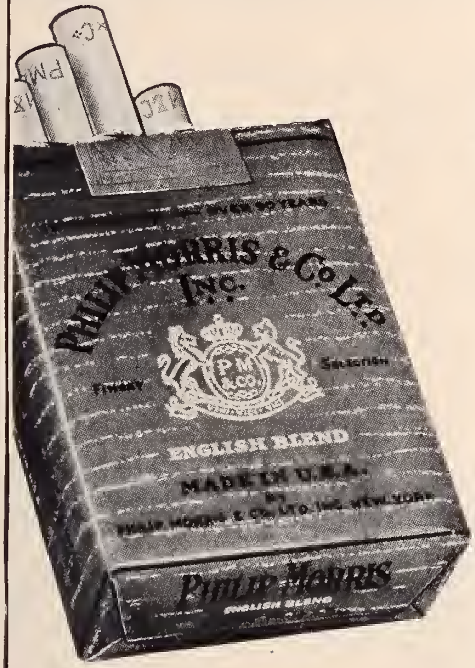

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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Penicillin-C.S.C.—available as penicillin calcium as well as penicillin sodium—is packaged only in rubber-stoppered serum-type vials containing 100,000 Oxford Units. The vials are used in preference to sealed ampuls because they make for greater convenience in storing the solution and because they lessen the danger of contamination after the solution is made.

Only vials of 100,000 units are offered at present because experience designates them as the most advantageous size. If there IS a factor in therapy which may undermine or lessen the remarkable therapeutic efficacy of penicillin, it may be underdosage. Even if therapy is instituted late in the course of the disease, penicillin in many instances will prove effective if adequately high dosage is used for the proper length of time.

In the conditions so far explored and reported, effective dosage in some instances will be less than 100,000 units per day; in many instances it may have to be several times this amount Hence in a large percentage of cases the Penicillin-C S.C. vial of 100,000 units will prove most advantageous.

The convenience of the vial will be readily appreciated. After removal of the tear-off portion of the aluminum seal, sterilize the exposed surface of the rubber stopper

For the usual concentration (5000 Oxford Units per cc.) inject 20 cc. of physiologic salt solution into the vial in the usual aseptic procedure.

Invert the vial and syringe (with needle in vial), and withdraw the amount of penicillin solution required for the first injection.

Store vial with remainder of solution in refrigerator. Solution is ready for subsequent injections during the next 24 hours.

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in the customary manner, inject into the vial 20 cc. of pyrogen-free, sterile physiologic salt solution; without removing the needle invert vial and withdraw as many cc. of this 5000 units per cc. solution for the injection that is to be made immediately; store the vial with its remaining solution in the refrigerator—it is ready for use when the next injection is to be made.

The concentration withdrawn from the vial is 5000 units per cc. If a lower concentration is desired, modification is easily accomplished.

If you have not as yet received a copy of the "Penicillin-C.S.C. Therapeutic Reference Table," showing dosages, modes of administration, and duration of treatment required in the various infections in which penicillin is indicated, write for a complimentary copy now. You will find it a valuable aid in familiarizing yourself with penicillin therapy.

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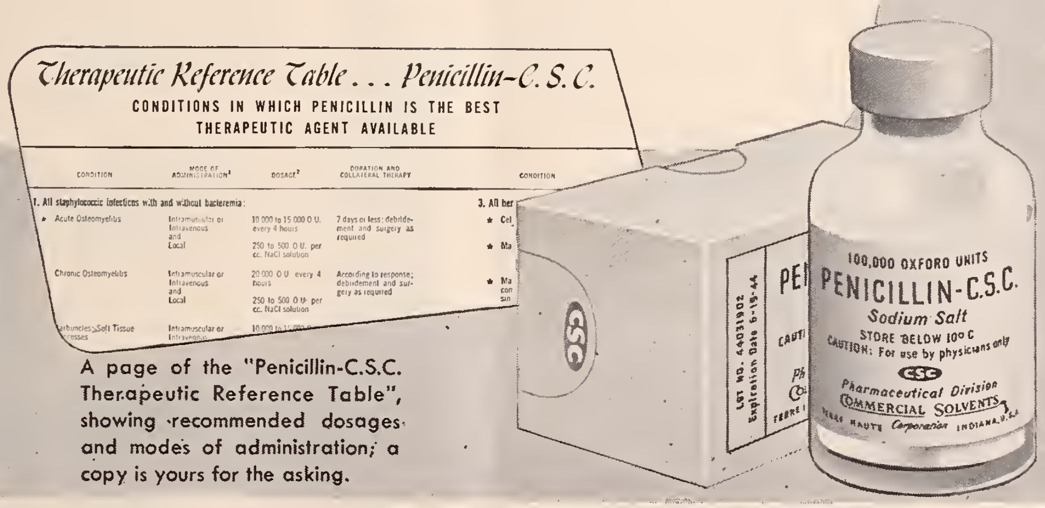

Therapeutic Reference Table . . . Penicillin-C. S. C.

CONDITIONS IN WHICH PENICILLIN IS THE BEST THERAPEUTIC AGENT AVAILABLE

CONDITION	MODE OF ADMINISTRATION[1]	DOSAGE[2]	DURATION AND COLLATERAL THERAPY	CONDITION
1. All staphylococcic infections with and without bacteremia:				**3. All her**
★ Acute Osteomyelitis	Intramuscular or Intravenous and Local	10 000 to 15 000 O U. every 4 hours 250 to 500 O U. per cc. NaCl solution	7 days or less; debridement and surgery as required	★ Cel ★ Ma
Chronic Osteomyelitis	Intramuscular or Intravenous and Local	20 000 O U every 4 hours 250 to 500 O U per cc. NaCl solution	According to response; debridement and surgery as required	★ Ma con sin
arbuncles, Soft Tissue cesses	Intramuscular or Intravenous	10 000 to 1		

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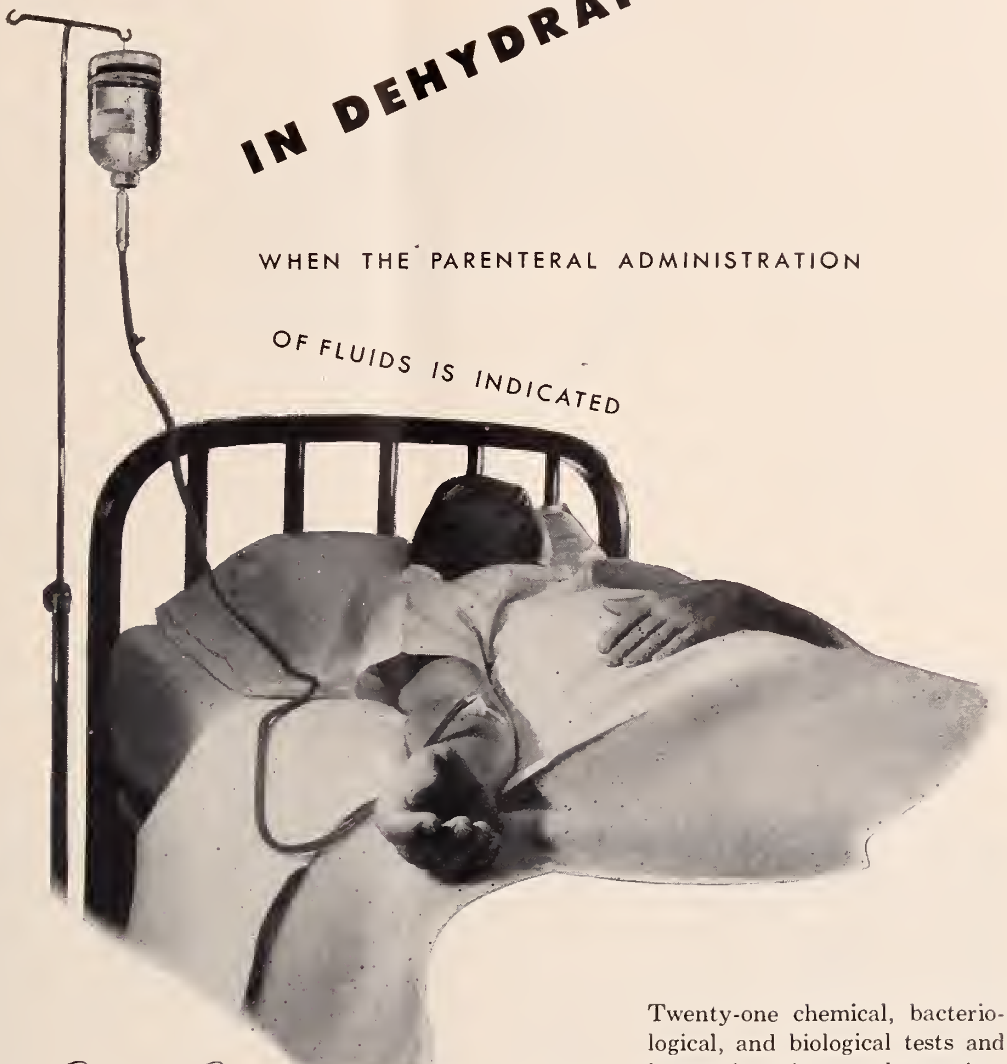

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BOOKS RECEIVED

(Continued from Page 10)

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1943, with the comments that have appeared in the Journal. Cloth. Pp. 150. Chicago, Illinois: American Medical Association, 1944.

BOOK REVIEWS

New and Nonofficial Remedies, 1944, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1944. Cloth. Price, postpaid, $1.50. Pp. 778. Chicago: American Medical Association, 1944.

The current volume of New and Nonofficial Remedies reflects two important and forward looking decisions of the Council, namely, to use the metric system exclusively in all its publications, and to consider for acceptance contraceptive preparations offered for use as prescribed by physicians. These decisions in turn reflect the vigorous and progressive leadership of the Council in the service of Medicine.

The chapter on contraceptives is quite comprehensive; with the acceptance of more preparations, it will undoubtedly assume a large place in New and Nonofficial Remedies. The Council has thus far accepted some contraceptive jellies and creams, contraceptive diaphragms, diaphragm inserts, syringe applicators, and fitting rings. It is understood that a number of additional preparations have been submitted for Council consideration since the book went to press. This chapter represents a courageous and long-needed innovation.

Some of the new preparations that appear in this volume are: Succinylsulfathiazole, a new sulfonamide, a

(Continued on Page 26)

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Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

Committee on Publications

Francis E. Toomey.........................San Diego 1945
George W. Walker (Chairman)..............Fresno 1946
F. Burton Jones............................Vallejo 1947
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Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

PUBLIC OPINION CONCERNING MEDICAL PRACTICE IN CALIFORNIA

"Interpretative Report" Appeared in May Issue of C. and W. M.—The "Interpretative Report on a Survey of Public Opinion Concerning Medical Practice in California," by Mr. John R. Little of Los Angeles of the firm of Foote, Cone and Belding, which appeared in CALIFORNIA AND WESTERN MEDICINE for May, 1944, on page 241, has already received much publicity in the medical press. It will no doubt be given much more as significance and value of the suggestions therein made are appreciated by members of the medical profession and others who are interested in plans designed to provide adequate medical care for all citizens of the United States.

The "Interpretative Report" should be read by every member of the California Medical Association. Physicians of other States who do not have access to CALIFORNIA AND WESTERN MEDICINE will find digests in *Medical Economics* for July, on pages 53-58, and for August, on pages 71-77.

* * *

Many Medical Surveys Have Been Made.—Medical surveys are nothing new, the report of the Committee on the Costs of Medical Care, consisting of 28 volumes, and of which Dr. Ray Lyman Wilbur of Stanford was chairman, being a notable example. That report, put out by the University of Chicago Press in 1932, laid the foundation for numerous other investigations, among which may be listed our own lamented "California Medical-Economic Survey" of 1934-1935. The California endeavor was produced in conjunction with the FERA (Federal Emergency Relief Administration). The C.M.A. money contribution to the well-intentioned, but unfortunate effort was in excess of fifty thousand dollars, a like sum having been received from Federal sources. That is a past experience, however, and is mentioned only to show the alertness of the medical profession of California on what was transpiring.

* * *

The C.M.A. Survey of November, 1943.—The C.M.A.'s recent November, 1943, survey on California Public Opinion cost some eight thousand dollars, but the members of the House of Delegates who listened in Los Angeles to Mr.

Little's illuminating report, agreed that the money had been well spent and full value received. If there be any doubting Thomases, before expressing contrary opinions they should read the reports. The address of Mr. Little to the C.M.A. House of Delegates appeared in California and Western Medicine for July, on pages 10-16, and is well worthy of more than one perusal.

* * *

C.M.A. Members Should Study the Two Reports of Mr. Little.—Every C.M.A. member should scan the two reports made by Mr. Little. The suggestion is also submitted that every one of the 40 component county medical societies in the State should set aside the whole, or at least a half of the time of an early meeting, at which the findings contained in the two reports could be discussed. County Program Committees might well appoint two to four members to lead the discussions on the factual and other information that was gathered and summarized in the reports. Through such procedure, members of the California Medical Association would build up, among themselves, a common understanding on the nature of existing problems in medical practice—regarding legislative trends — and thus be in better position to properly discuss the various phases of these important matters with colleagues, patients, and friends. For it is only through dissemination of knowledge dealing with actual facts and figures, that the basic principles, truths and future implications of medical practice may be visualized. It follows that physicians must themselves first understand the subject concerning which they would educate lay citizens.

It is not the purpose of these present comments to discuss the factual and other data so admirably placed by Mr. Little before all who will take the time to scan them, but rather to impress upon every physician who may see these lines, his individual responsibilities—in line with the Hippocratic oath,—to be loyal to his professional obligations to do all within his power to promote efforts designed to maintain the best quality of medical service for all classes of human fellows.

For those C.M.A. members who may be skeptical about all this, nothing more need be said, other than to ask them to read between the lines of items constantly appearing in newspaper and magazine press, and if they will, also turn, in California and Western Medicine, to the articles which appeared in the March number, on pages 110-111, on "Pros and Cons Concerning the Wagner-Murray-Dingell Bill (S. 1161)",—and in subsequent issues, such as the July number, on pages 39 and 40,—in order better to orient themselves on some of the plans now being propagandized among that massive number of voters who belong to labor organizations such as the A. F. of L. and C. I. O.

If space were available, the temptation would be to use it to briefly recount recent experiences which have been had by some officers and representatives of organized medecine, as they sat with spokesmen of such labor and other groups, in round table discussions of medical service problems.

* * *

Value of the Recent Survey.—The Foote, Cone and Belding surveys, outlines of which have appeared in California and Western Medicine in the references cited above, give accurate comment and conclusions on the matters here referred to. No Doctor of Medicine in California, or, for that matter, of any other State in the Union, should delude himself into thinking that these present-day agitations for a new and radically different form of medical practice are ephemeral manifestations, or so-called "flashes in the pan," that soon will dissipate themselves into thin air and nothingness. They are not. They are the expression of well defined convictions on the part of probably a majority of citizens that somewhere, somehow, the proper and adequate medical care of all classes of citizens is deficient. Since this opinion is so widespread, and the medical profession has been picked out for blame, it is not surprising that these voting citizens, under the propaganda influence to which they have been subjected, are willing to accept plausible solutions for manifest errors in the distribution of medical care. These lay fellows are not in position to understand that, in the long run, regimented methods of medical practice, under political control, will lead to lower standards of medical care than those now in operation, procedures which have been developed under a system of free enterprise, wherein there has been fair reward for individual initiative, efficiency and better service.

* * *

Proper Understanding of Medical Trends Is Essential.—Wherefore, it behooves all Doctors of Medicine to sense the kind of world they are now living in, and to study trends in relation to the practice of their own profession. Only so, through better coöperative understanding and mutual effort, will the medical profession be able to assure for the people of our Country, a perpetuation of attainment in public health service that will be characterized by continued betterment through evolutionary methods, of low morbidity and mortality records for our Nation, and thus, the achievement of better health for the people of our Nation.

In all this, we need not, nor should we look to Europe for examples to map our own courses of action. What is transpiring in Europe today, is adequate evidence that those peoples, from whom our own forbears sprang, have much to learn concerning better standards of living, and that for such, they may come to us. Let us be loyal to the traditions of our own past in public health achievements in America, and on that foundation, determine to continue on for the accomplishment of even greater and more beneficent results.

To do this, however, as already stated, we must know what is taking place in our own midst, both in California and the other States. A study of the two reports by Mr. Little will promote a better understanding of the medical practice and distribution problems awaiting solution.

CALIFORNIA PHYSICIANS' SERVICE

C.M.A. House of Delegates as Board of Administrative Members of C.P.S.—In CALIFORNIA AND WESTERN MEDICINE for June, 1944, on page 294, note was made in the minutes of the C.M.A. House of Delegates concerning a recess during which members of the House again convened, but this time as the Board of Administrative Members of California Physicians' Service. The minutes of the two C.P.S. meetings appeared on pages 329-333, and further comment was given place on page 345. The medical service organization, California Physicians' Service, was brought into being by the California Medical Association. With the C.M.A. House of Delegates constituting its group of Administrative Members, it is now, more than ever, the child of the State Medical Association. Therefore, the perusal of those minutes should take on additional interest. The fact that California's statewide plan of medical service for certain low income groups is at last on a sound foundation, with a bright outlook for the future, is heartening to those C.M.A. members who, with good wishes for its success, have kept in touch with its development.

Skeptics should keep in mind that the president of the Board of Trustees of California Physicians' Service is Dr. Ray Lyman Wilbur of Stanford, who has never been in the habit of permitting his name to be used in promotion of plans that did not have fundamental merit and legitimate objectives. That he was willing to accept the office of president when C.P.S. was organized, and remain with it as it was striving to work out its career, is a tribute both to his good judgment and loyal spirit of coöperation.

There may be some physicians who still look somewhat askance at C.P.S. In justice to themselves and their State Association's medical service organization,—C.P.S.—they should take the time to scan the references given above, and also the report in the current issue, which appears on page 119.

* * *

C.P.S. Is No Longer in the Red.—In this last report, it is stated that California Physicians' Service, as a going concern, in the last fiscal year, did a business totaling $1,340,315.00, which all fair-minded persons must concede is a respectable sum. Accretions of new beneficiary members (patients) are now proceeding at a rate of something like 8,000 new members each month. If members of the profession will lend all possible aid, that figure can be materially increased.

With a unit value of $2.25 in operation, and new bookkeeping arrangements, whereby in the future it will be possible to pay physicians promptly for services rendered,—in short, almost as soon as statements are properly submitted,—and payments made according to a schedule that compares most favorably with fees otherwise received from persons in the low income groups to whom the professional services are rendered, and with absolutely no loss through bad or nonpaying accounts, there is today little basis for legitimate criticism of this California Medical Association plan to provide adequate medical service for the large group of low income citizens, for whom, particularly, C.P.S. was brought into existence.

It is not contended that mistakes in policy and administration have not been made by C.P.S. during the last five years, but the errors have not all been one-sided. We should not forget that our State Association, through its House of Delegates,—after warm discussion running over several years,—saw fit to promote a statewide medical service organization. California Physicians' Service was the first statewide and comprehensive health coverage plan to be organized under the sponsorship and control of a constituent state medical society. Because the original set-up was too idealistic—there being little real actuarial background upon which to base a foundation for the organization—it is not to be wondered at that, in the light of later and greater experience, some errors should have been made. However, by the hard way, through the trial and error method, California Physicians' Service has gradually found itself, and today it is a going concern, "not in, but *outside* the red." The number of beneficiary members (patients) is steadily increasing, and there is also a substantial decrease in costs of operation.

* * *

C.M.A.'s Plan of Medical Service Is Under Close Observation.—The California Medical Association has the distinction of having promoted the largest statewide medical service plan in the United States, and the experiment is being carefully watched by keen observers—both governmental and nongovernmental,—from one end of the United States to the other.

It is agreed that in some portions of our State there has been legitimate basis for criticisms that have been made concerning California Physicians' Service. However, it is the belief of the constituted authorities of the California Medical Association—the members of the C.M.A. Council—that from now on, the record of C.P.S. will be increasingly favorable. It is also the hope of all who have borne special responsibilities in relation to C.P.S., that in those areas where unhappiness and disaffection have existed in the past, members of the California Medical Association will be willing to again take stock of the situation, as it exists today, and insofar as individual and collective support is possible, give the same to the further and future promotion of California Physicians' Service.

If, from now on,—forgetting the mistakes of days gone by,—all can work together, it should be possible for the medical profession of California to point the way and indicate the paths whereby adequate medical service may be made available to citizens of low income groups, and that, without governmental intervention, control and regimentation.

Certainly, such a happy consummation should appeal to every member of the California Medical Association, and all should work for so laudable an objective.

NEXT YEAR'S ANNUAL SESSION

The Meeting Dates for 1945 Are May 6-7.—In May last, the House of Delegates approved the recommendation of the Council that next year's Annual Session shall be held on Sunday-Monday, May 6-7, 1945, in Los Angeles. That will mark the third successive year in which the Los Angeles County Medical Association will have been the nominal host of the California Medical Association.

Reasons for the selection are simple: the Association has thirteen Scientific Sections, a House of Delegates, a Council, and a Woman's Auxiliary; and for each of these separate activities, a meeting room is needed. The Hotel Del Monte, where the C.M.A. has met year after year, is now a Navy institution; San Francisco, at present a major port of embarkation, finds its hotels constantly filled to overflowing; consequently, the Hotel Biltmore in Los Angeles, with its battery of conference rooms, is the only hostelry in which even approximate meeting needs can be provided. Therefore, during the Duration, it may be assumed that we will continue to meet in Los Angeles, provided the Hotel Biltmore is available.

* * *

Advice to Prospective Essayists.—The above comments having been made, it is now in order to remind members of the California Medical Association who are in position to coöperate, to write to the proper Section Secretary (or to the Association Secretary, who is chairman of the Committee on Scientific Work) concerning possible papers to be presented at Section or General Meetings. Members who are interested in special topics are also invited to send in suggestions. The C.M.A. Committee and Section Officers will be happy to receive such. No scientific exhibits are contemplated. Following the procedure in operation during the last two Annual Sessions, next year's—the C.M.A.'s Seventy-fourth—will be limited to two-day, streamlined meetings. The two days thus designated,—Sunday and Monday,—make for greater ease in attendance, since appointments and other professional work can be better set aside at that period of the week.

Members should keep the next Annual Session in mind, and if possible, make plans to be present. During these strenuous days, the interchange of opinion on old and new problems is as much needed as ever. With the large membership in the Los Angeles County Medical Association, in excess of two thousand, there exists a substantial nucleus for a successful session. Make plans to be among those who will be present.

EDITORIAL COMMENT†

POTENTIATED INFLUENZA VACCINE

Ten years ago Burky[1] found that while autogenous lens and muscle proteins are apparently nonantigenic for rabbits, both become effective antigens when combined with staphylococcus filtrate. Using the combined antigens rabbits can be readily sensitized to their own crystalline lens and skeletal muscles. Such rabbits produce sufficiently high titer anti-lens or anti-muscle precipitins to cause degenerative lesions in its own homologous tissues.

Since publication of these results the suggested possibility of enhancing the immunizing power of numerous relatively unsuccessful vaccines by the addition of adjuvants has been the subject of numerous investigations. Ramon[2] found that the addition of lanolin to diphtheria toxin enhances antitoxin production. Freund[3] noted that the addition of paraffin oil enhances the antigenic properties of heat-killed tubercle bacilli. Landsteiner[4] was able to sensitize animals to certain relatively simple chemical compounds by means of simultaneous intraperitoneal injection of these compounds and heat-killed tubercle bacilli suspended in paraffin oil.

Combining these suggestive leads Freund[5] of the Department of Health, New York City, attempted to maximize the antigenicity of horse serum. The horse serum was added to an equal volume of "aquaphor," a lanolin-like substance which possesses a much greater water-absorbing capacity than lanolin. There was then added to the mixture an equal volume of paraffin oil containing 2 mg. per c.c. of vacuum dried, heat-killed tubercle bacilli. The resulting emulsion was injected in 0.5 c.c. doses intramuscularly into full-grown guinea pigs. Each dose contained 0.125 c.c. horse serum, 0.125 c.c. of the lanolin-like substance, 0.25 c.c. paraffin oil and 0.5 mg. heat-killed tubercle bacilli. Control animals were injected with the same dose of horse serum diluted with saline solution.

The animals were tested for sensitivity by intracutaneous injections of graded dilutions of horse serum at various intervals during the next 12 months. Necrosis occurred frequently at the site of the injection of 10 per cent horse serum in groups sensitized with horse serum plus adjuvants, but was never noted in control groups sensitized with horse serum alone. The contrast was particularly striking in animals tested one year after sensitization. Tested with 1:10 dilution of horse serum a typical late reaction in the adjuvant groups was an area of redness 35 mm. in diameter, with a 3 mm. swelling. The reactions were wholly negative in the control groups.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Four weeks after the antigenic injection the serums of the control groups gave an average + precipitin reaction when tested with a 1:10 dilution of horse serum, but negative precipitin reactions when tested with a 1:100 serum dilution. The groups sensitized with horse serum plus adjuvants gave +++ precipitin reactions with 1:10 serum dilution, and + reactions with dilutions as high as 1:1000. This suggested that the addition of the immunologic adjuvants increases the immunizing power of horse proteins at least 100-fold.

A most promising practical application of the Freund technique is currently reported by Friedewald[6] of the International Health Division, Rockefeller Foundation. He blended allantoic fluid suspensions of formalin-killed influenza virus with a half volume of the lanolin-like substance "falba." To this was added an equal volume of paraffin oil containing heat-killed virulent tubercle bacilli. Each c.c. of the resulting emulsion contained 1.5 mg. of the vacuum dried tubercle bacilli. He tested the immunizing capacity of a single 0.5 c.c. subcutaneous injection of this emulsion on young adult Swiss mice. Control mice received the same amount of allantoic fluid diluted with saline solution. A third control group was injected with saline solution alone.

Mice of each group were tested for antiviral resistance by intranasal instillation of graded doses of homologous influenza virus. He found that, 4 to 8 weeks after vaccination, mice that had been injected with the non-viable virus alone were resistant to about 100 MLD of homologous living virus. After 26 weeks no post-vaccination immunity could be detected. In contrast, mice vaccinated with virus plus Freund adjuvants were resistant to about 1,000,000 MLD of homologous virus 4 to 8 weeks later, and to at least 1,000 MLD at the end of 26 weeks. The Freund adjuvants apparently increased the immunologic efficiency of the formalin-killed influenza virus approximately 10,000-fold.

The same contrast was noted in the relative antibody response of ferrets injected subcutaneously with formalized influenza virus with or without Freund adjuvants. The specific antibody titers were determined by the Hirst[7] inhibition technique. In the control group injected with the virus alone the mean titer rose to 388 Hirst units by the end of 2 weeks. From this it gradually fell to 91 Hirst units by the end of 18 weeks. In the group injected with virus plus Freund adjuvants, the titer rose to 10,000 units by the 3rd week, gradually falling to 2,520 units by the end of 18 weeks. There was thus an apparent 27-fold increase in antibody power as a result of the Freund adjuvants.

Friedewald found that another acid-fast organism, Mycobacterium butyricum, could be substituted for the tubercle bacilli in the Freund emulsion with no decrease in its immunizing power. He is of the opinion, however, that it is unlikely that any adjuvants thus far tested can be safely used in human medicine. Attempts to find safer adjuvants are now in progress.

There is as yet no generally accepted theory as to the mechanism of adjuvantic potentiation of weak vaccines.

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RIVER FEVER GROUP-RICKETTSIAL DISEASE (TSUTSUGAMUSHI FEVER)*

Recently, on the Pacific Coast, much interest and discussion have centered around this rickettsial disease. Apparently, too, convalescent patients from military battle areas are being returned for further care and study. Therefore, it can be expected that "River Fever" will be investigated in all its phases, especially as to treatment and its possible control. Certain well-known characteristics and sufficient data, however, have been accumulated from which some comments may be timely.

At the very first, there may be pointed out that the classification of all rickettsial diseases, their various clinical and vector factors, and areas of distribution have undergone many changes in the past few years. The insect vectors of Tsutsugamushi Fever are the mites Trombicula akamushi and deliensis, and the animal carrier of these insects is mainly the field mouse, Microtus montebelloi. The heretofore recognized area distributions have been Japan, South Asia and certain Pacific islands. On the Pacific Coast there has been observed on rats, the presence of a mite, Liponyssus bacoti, but its relation to the spread of any of the rickettsias is not proved.

The field evidence of infections from "River Fever" concentrates on visible indications of insect bites, usually occurring near the groin, genitalia, axilla, back or extremities, and the presence of mites identified as vectors. Quite often there is left some pigmentation or necrotic bases at the bite sites. The symptoms, within ten days of the insect bite, of fever, malaise, headache, tender glands, skin eruptions and hyperasthesia, impaired hearing, parotitis, stomatitis, bronchitis, pneumonitis or pneumonia with leucopenia, enlarged liver and spleen, offer a probable clinical diagnosis. Convalescence may be quite prolonged and immunity not well established. Whether some recovered cases may remain carriers, deserves further investigation. Such diagnoses are mainly dependent on exposure to insect bites in known infected areas, skin-rash and fever, and the Weil-Felix agglutination reaction with B. proteus strain antigen OXK. The case mortality may reach as high as thirty per cent.

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* From the Department of Public Health, San Francisco, California.

Obviously, the prevention of this disease offers many difficulties under military field conditions of modern warfare, but the control of rodents and their accompanying insects is a world-wide problem, and must be given more diligent attention by public health officials everywhere. Once a disease, capable of being transmitted to man, is established in rodents in any community, all known control measures are mandatory, and continuity of these measures should never be broken.

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GRANULOCYTOPENIA: A CASE CAUSED BY THIOURACIL

ANDREW H. MEYER,* M.D.
Oakland

WHEN a new drug is being evaluated, we believe that the toxic reactions encountered in its use should be made known. For that reason, we are reporting an instance of marked granulocytopenia caused by thiouracil.

REPORT OF CASE

A colored male, aged 40, entered Highland-Alameda County Hospital on February 2, presenting the classical symptoms and findings of a diffuse toxic goitre with exophthalmos. The initial laboratory findings revealed a basal metabolic rate of plus 40, serum cholesterol of 140 mgm. per 100 c.c., normal white and differential blood counts, and negative x-rays of the chest and soft tissues of the neck.

On February 16th, the patient was placed on thiouracil, .2 grams every eight hours. By March 28th, the patient had gained 15 pounds in weight, the basal metabolic rate had decreased to plus 13, and the serum cholesterol had increased to 190 mgm. per 100 c.c. There was a noticeable decrease in the exophthalmos. However, there had not been a corresponding decrease in the nervous symptoms, and for that reason the dosage of thiouracil was increased to .4 grams every eight hours, on March 29th. Between April 6th and April 11th our supply of thiouracil became exhausted, and subsequently the dosage of .4 grams every eight hours was resumed on April 12th.

On April 16th, after having received 40.8 grams of thiouracil in 55 days, the patient experienced a severe chill, the onset of a severe sore throat and a temperature rise to 104° F. He appeared acutely ill, the throat was red and edematous, and the gums appeared pale and contained patches of pseudomembrane. There was a moderate cervical adenitis. A white blood count showed 2,000 cells, with 19 per cent segmented forms, 3 per cent juveniles, and 71 per cent lymphocytes. One week previously the white blood count had been normal. For the next 6 days, the patient appeared toxic and ran a swinging temperature between 101° F. and 104° F. His total white blood count remained at 2,000, but the differential count decreased to 1 per cent segmented forms, 6 per cent stab forms, 3 per cent juveniles, and 90 per cent lymphocytes.

Therapy consisted of discontinuing the thiouracil, isolating the patient from exogenous infection, atraumatic oral care with normal saline mouth washes, a high vitamin C intake and 10 c.c. of pentnucleotide intramuscularly four times daily. However, after each of three injections of pentnucleotide, the patient experienced such severe nausea, vomiting, and chills that the pentnucleotide was discontinued. Liver extract, 5 c.c. intramuscularly, was given twice daily, and in addition sulfadiazine was given orally. Ten days after the onset of the granulocytopenia the white blood count and the differential count had returned to normal.

DISCUSSION

Astwood[1] has reported an instance of agranulocytosis developing from the use of thiouracil in a dosage varying from 1-2 grams daily over a period of 36 days. Gabrilove and Kert,[2] and Palmer,[3] have noted instances in their series of cases in which the total white cell count has been depressed although there was no depression in the percentage differential count.

CONCLUSION

Thiouracil, a new drug in the treatment and preoperative preparation of hyperthyroid patients, is capable of producing marked granulocytopenia and even agranulocytosis.

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Public Spends Too Much on Vitamins

The American people are spending too much on vitamins, Dr. Herman L. Kretschmer of Chicago, new president of the American Medical Association, declared on June 13, 1944.

He said the estimates are that Americans this year will spend about $250,000,000 for vitamins.

"I do not wish," he declared, "to discredit the enormous progress that has been made in this field. Certainly the people of this country are not in such a state of malnutrition as to require the use of $250,000,000 worth of vitamins.

"The excessive claims made for vitamins are beyond any basic evidence. One is impressed by the close parallelism to the 'patent medicine' advertisements of 25 years ago."

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* From the Highland-Alameda County Hospital.

ORIGINAL ARTICLES

Scientific and General

NEW PROBLEMS IN THE FIELD OF THE INDUSTRIAL TOXICOLOGIST*

Alice Hamilton, M. D.
Boston, Massachusetts

I ALWAYS feel apologetic when I face a general medical audience because my specialty is such a small and relatively insignificant one.

Even industrial medicine is only one of the lesser specialties, and when I cover only a part of that, industrial toxicology, we get down to a very small specialty indeed. It is, however, very gratifying to me to find that the California Medical Society considers it important enough to devote time in their First General Session to a discussion of the newer problems of industrial toxicology.

In speaking of them I want to include also older problems which have been with us a long time, but which have increased in importance with the war. To begin with there is that very important feature of industrial poisoning which cannot be emphasized too often and whose importance has increased, and that is the factor of clean air, for we must not forget that the great majority of industrial poisons enter the human body by way of the breath, not through unwashed hands, and only to a limited extent through the skin. That does have to be emphasized over and over again.

I am sure you all remember how long we were led astray in the attempt to control lead poisoning by insisting upon men washing their hands before they ate their lunch, scrubbing their nails. I used to feel that I was pursued by a nightmare of scrubbing the nails and never have I been able to understand how the doctor reasoned out that the lead under the man's nails got into his body and poisoned him. But it was nail brushing that was always emphasized back in the days when I first went into industrial medicine. Of course we got away from that. But it took us a long time.

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I well remember a great smelter-refinery on the Atlantic Coast which, when a compensation law for industrial diseases was passed in the State of New Jersey, was faced with the problem of doing something about lead poisoning. They consulted a so-called expert who told them to put up a comfort house, with showerbaths, hot and cold water, provision of soap and towels and even of washable uniforms for the men. At the end of the year they had just as much lead poisoning as ever, because, of course, nobody had thought of fumes and dust, and the men were breathing just the same sort of air.

I do think in the control of lead poisoning we have left that position far behind. But not very long ago I read an article by an eminent physician on the prevention of benzol poisoning and he started out with, "Bodily cleanliness is of prime importance in the prevention of benzol poisoning." Well, I should simply have changed that sentence to, "Bodily cleanliness is absolutely of no importance in the prevention of benzol poisoning." A man could not protect himself against breathing benzol fumes no matter how cleanly he was in his habits. It is misleading. It is partly the subconscious comfort that a man gets in being able to pass on to the worker the responsibility for a very distressing occurrence, a case of occupational disease, and to that temptation a good many men do succumb.

* * *

In the war industries it is increasingly important that the air be kept clean. For one thing, we use heat more than we have ever done before. And heat has a great importance in three ways. In the first place, all of our estimates of what we call the maximum allowable concentration of a poison in the air are based upon an eight-hour day, the amount of air that a man will breathe in during that eight-hour day at an ordinary rate and depth of respiration. But heat increases the depth and the rapidity of respiration. Heat makes a quantitative increase in the amount of poison a man absorbs.

In the second place, heat causes sweating of the skin, helps the solution of the poisonous dust that has fallen on the skin, and this is of enormous importance in those poisons, the derivatives of the coal-tar group, which enter primarily through the skin. That includes TNT and others of our explosive poisons and heat also dissolves the poisonous dust and by flushing the surface vessels hastens the absorption by the skin.

In the third place, heat aids in the volatilization of a volatile poison.

We have increased our hot jobs. We have substituted welding for riveting to a great extent. We use hot degreasing instead of cold degreasing. When I first saw degreasing, the metal parts to be degreased were put in baskets and dipped in great tanks of cold degreaser, usually carbon tetrachloride, then later on trichlorethylene. As you can imagine, as the dipping went on more and more grease got into the tank and diluted the degreaser too much, so that toward the end of the day it was not working well at all. Now they degrease with the fumes, and no matter how much grease is down in the tank, so long as the fumes come off, the fumes do the degreasing. Of course that increases very much the danger of poisoning from these volatile solvents which are none of them non-toxic. All of them are narcotics and some have a very distinct damaging effect upon the organs.

Of the two favorite ones, carbon tetrachloride and trichlorethylene, we always prefer the latter because although all of the chlorinated hydrocarbons are poisons, the unsaturated, such as trichlorethylene, are much safer. They are strong narcotics, stronger than the saturated, but they do not attack the liver and kidneys. Carbon tetrachloride, which is tetrachlormethane, is a saturated compound (as is chloroform, or trichlormethane).

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* Guest Speaker's Address. Alice Hamilton, M. D., is Professor Emeritus, of Industrial Medicine, Harvard University Medical School. Given before the First General Meeting, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

There is also an increase of youthful workers. I am not going to say anything about the increase in the use of women, that has very well been dealt with by experts who know more than I do because my specialty has had to do predominantly with men's trades. But the increased employment of youthful workers is a serious feature when you consider the poisonous trades. I have been told that we have no statistical proof of the increased danger of poisons to the youthful. Well, I think we have some, not very extensive or impressive, but in the first World War we found a distinct, marked difference in the resistance to TNT poisoning between the men under twenty-one years of age and the men over thirty years of age. It was very striking, so much so that we notified the War Department that they were wasting time in employing young men. Of course, it did not have any effect, but still we did notify them.

The English found, in connection with ether poisoning in the making of smokeless powder, that the young girls were far more susceptible. In connection with trichlorethylene, we do a great deal of experimenting in Connecticut, and anyone who has had experience with it will tell you that a young girl is more likely to pass out than an older woman. Then William Schmidt of the Children's Bureau points out that the immature organism breathes in a greater volume of air per unit of body weight than does the adult, has a greater surface of skin for absorption per unit of body weight and a more rapid circulation, all of which would work to the more rapid taking up of the poison and a more rapid circulation through the body.

If, and I hope it will not come to pass, we have an opportunity to see what the poisons do to the young, we should certainly gather statistics to be able to settle this question. But it has never yet been true in this country that large numbers of young people have been exposed to trade poisons and I do not believe it will be true. That is why it has been so hard for us to get any real information on the subject.

We have never employed young people in the poisonous trades to any extent, and the Children's Bureau has now been given a good deal of authority to forbid the employment of young people under conditions which the Bureau finds dangerous.

* * *

Some of the old and familiar poisons are coming in with new trades or coming back in old trades. I went over a great shipbuilding plant at Fall River, Massachusetts, a few years ago and was very gratified to find they were not using lead paint. They said the navy had given it up and so they gave it up for all of their ships. That seemed to me a great step forward. Then not very long ago I was told that although the navy still, and I believe it is true, does not use lead paint, the Maritime Commission does, and that now the hulls of ships are being sprayed with red lead paint. I do not know how carefully the men who are doing the spray painting are protected, out of doors mind you, with the wind blowing toward them—you could hardly expect the men could get to the windward of the spray all of the time—nor do I know how they can be protected. It would have to be of course personal protection, with an air helmet or a positive pressure mask if the protection is to be adequate. Anyway that danger has come back after we had thought it was quite sidetracked.

* * *

Benzol has come back in rubber manufacture, although I was assured last night by three physicians connected with rubber companies that now it is possible again to get toluols and the large rubber companies have gone back to this much safer solvent. For months after the war began, toluol was needed for TNT. It is not so good a solvent as benzol but they use it because they want to protect their workers.

* * *

Tetrachlorethane has come back. Physicians learned during the last war from a bitter experience, first in Germany, afterwards in England (fortunately we were warned in time) that tetrachlorethane is the most poisonous of all the chlorinated hydrocarbons. (About penta and hexa we know little.) The cases in the British factory inspection reports are listed under toxic jaundice, along with arseniuretted hydrogen cases. And that is the form it takes in the majority of cases, an acute yellow atrophy of the liver, although there is also a form which attacks the marrow of the bones and results in aplastic anemia, and the Germans reported some cases that were purely nervous in character. But in the last war we were, as I say, warned in time; we did not have cases.

The few cases we saw came after the war, when they began making artificial silk as we called it then—cellulose acetate silk—the best solvent for the acetate being tetrachlorethane. One of these factories was near Boston and I saw the first case of jaundice which developed there. The management at once instituted all possible precautions and soon changed to another solvent, and, so far as I know, tetrachlorethane was not used in industry in the years between the two wars to any extent. Now I find it on the lists of the Bureau of Standards and the army and the navy as a very valuable solvent. Well, it is. But if you were thinking of the producer and not the product you would not touch tetrachlorethane.

* * *

There is great increase in the use of halowax, which is a mixture of chlorinated napthalenes. That is a curious situation. Halowax has been used for many years. You know it is a very good insulating material, practically essential for covering electric wires. Here, and in England and on the Continent, it was used for years with no more serious effect on the users than a pustular acneiform eruption. Then suddenly and most mysteriously a few cases of acute yellow atrophy of the liver appeared in Connecticut and Massachusetts in men working with halowax. Fortunately the Industrial Hygiene Bureaus of those two States have very alert men in charge. In former years nobody would have thought of any occupational connection with such cases, because there was nothing in the literature to indicate it.

Correspondence with the European authorities threw no light on the problem, no cases of liver damage had ever been reported, but A. S. Grey of Connecticut and Bowditch of Massachusetts could not escape the belief that their cases were occupational in character. Confirmation came from New York. Leonard Greenburg, of the Bureau of Industrial Hygiene, discovered a number of cases in the following two years, not a large number, but two in one plant and I think four in another, and a far larger number of nonfatal cases, all of acute degeneration of the liver. Autopsies showed typical acute yellow atrophy. It transpired that what had happened was this: Abroad and for many years in this country, the lower chlorinated naphthalenes were used, chiefly trichlornaphthalene. Then, in the desire of our industrial chemists to obtain a faster and better method, they substituted the higher chlorinations, penta and hexa. That is where the trouble came in. The addition of those extra atoms of chlorine shot the danger up as it does every time. The larger the number of chlorine atoms, the greater the danger of injury to the liver. We are increasing the use of halowax very much and the warning is that, whatever form of halowax you use, the solvent must not be another chlorinated hydrocarbon, for that doubles the danger. Nor should any man work with halowax who has ever been exposed to any of the chlorinated hydrocarbons.

* * *

A number of new problems have come in that we did not have during the first World War. I think that one of the serious ones is the increased use of cracked petroleum. As you know, cracked petroleum is made by distillation at a heat so great that the molecules do crack up and you have as a result a change in the proportion of paraffins and olefins, and also the production of a certain quantity of aromatic hydrocarbons. the benzol group, which of course brings in a new danger.

In the early years of the century and in the first World War, when one found that a plant was using a solvent that belonged to the petroleum distillates, benzine, petroleum ether, naphtha, or whatever you called it, one felt that it was pretty safe. It was really the most harmless of the solvents used. Now you cannot feel safe with a petroleum distillate. My attention was called to this years ago, first by an article by Dr. J. Martin Askey of Los Angeles who ran down a case of aplastic anemia which apparently resulted from exposure to gasoline fumes. That was unbelievable but he found that the gasoline the man was using had a high proportion of benzol in it. Now since the cracking process, we have come to look for that in all places where the peteroleum distillates are used.

If you have a case of serious and unexpected symptoms in a worker in gasoline—and we do not expect anything more than a functional neurosis in such a worker—if there is real organic change, especially if it affects the blood picture, then our reasoning is that you have to do with coal tar benzol.

You do not have to look out for nitrous fume poisoning as much as we do in the Eastern plants where the explosives are produced. That was our great danger in the first World War because the production and the use of nitric acid were quite new in American industry, and engineers had not yet succeeded in coping with the situation. You know nitric acid eats through practically everything and it was always eating through pipes and machines resulting in sudden explosion and the pouring out of those angry yellow, deep orange fumes, and the men fleeing before them. And then some of them always breathed in enough of the fumes to give real trouble. But that danger has been dealt with by the engineers and we have very little nitrous fume poisoning in TNT and other explosives production.

How much there is in connection with welding we shall not know for some time. Very exhaustive studies, as you know, involving a very large number of welders, are going on in many plants with regard to what actually happens in welding. We started out thinking that the danger of nitrous fume poisoning was very great and I am afraid we are beginning to think that it is even slighter than it is. I do not know.

I heard a discussion on that very subject by Dr. Carey McCord, not long ago in New York and it seemed really that there was very little evidence of serious danger from nitrous fume poisoning in that work. But there are other dangerous fumes in welding at times. There is the possibility of manganese poisoning which to my mind is about the most distressing of the industrial poisons, because it is absolutely incurable, and so distressing in its effects. We are using much of it in steel and we are welding a great deal of the steel. Now we are beginning to have cases drifting in of manganese poisoning in welders.

* * *

Hydrofluoric acid and the fluorides have come into sudden prominence such as they never used to have. Hydrofluoric acid is, I think, dreaded by anyone who has ever had anything to do with its use. I used to be consultant to the General Electric Company and would go around to all of the Mazda Lamp Works where the frosted bulbs were produced, the frosting being done with a dilute solution of hydrochloric acid. I can assure you they used excessive precautions in that department. They were very much afraid of the burns on skin or in the eye. The next place I found it was in a factory making enameled sanitary wear, of the cheaper kind, enameled ironware. And there, instead of sand-blasting a defective coating to be able to put on a new one, they were dipping the ware in hydrofluoric acid, a use for this acid which I had never seen before. There, too, they were very apprehensive of both fumes and droplets. You know the slightest splash does cause such a very bad burn. I find hydrofluoric acid has a new use now as a catalyst in the production of light octane aviation fluid, and that the way it is used requires scrupulous care if trouble is to be avoided.

The fluorides also have suddenly become very important. Up to recently we knew of fluoride poisoning only from French descriptions, the "cachexia fluorica" of French cryolite miners. Cryolite is the double fluoride of aluminum and sodium. The French described a thickening and opacity, in x-ray pictures, of the bones, with exostoses and with calcification of ligamentous attachments, accompanied by the cachexia of anemia, loss of weight and gradual loss of strength. Then the Russians wrote about it and the Swedes, all of them in connection with cryolite mining.

We are just beginning to turn our attention to it in this country. Fluorides are very important, I believe, in the making of certain kinds of steel. The American cases that I have been able to find in the literature are very few. Wilton Kerr reported an autopsy on a man in whom the x-rays had shown dense shadows of the bones, and calcification of the ligamentous attachments: at autopsy the bones were found to be very thick and heavy, with wide, plate-like exostoses and a great excess of fluorine in the bones. The man had worked eighteen years in finely ground phosphate dust containing only 3.8 per cent fluorine but he had been at it a long time.

There is exposure to fluoride in magnesium foundries, where it seems to be used as an inhibitor, and the danger comes in the dusty jobs, the shake-out and the chipping. We have no data to indicate at what point the danger begins. We all know that a dilution of fluoride in the drinking water above a certain point produces mottled teeth but below that point the presence of fluorine in the drinking water is supposed to be actually beneficial. At what point it begins to be injurious to a greater extent than the production of just mottled teeth, which does not really matter much, we do not know. Hodges and his colleagues found in 1938 that mottled teeth were prevalent in a locality where there was a daily intake of water carrying 2.6 milligrams of fluorine, but they found no demonstrable effect on the bones. Even a man who had lived there and drunk that water for 68 years showed nothing. We need very much accurate data on the changes in the bones in all regions where fluorine is present in the water to an extent great enough to cause mottled teeth. Because we do not know now what the danger limit is.

* * *

Another of the poisons of which we knew apparently very little, and which has become very important, is cadmium. When one of my students at Harvard wrote a paper on cadmium, it was, I believe, in 1934, he was obliged to go altogether to foreign sources for his information. We had had no experience with cadmium poisoning. Dr. Prodan made experiments on animals and found that the effect of cadmium fumes is primarily upon the lungs, and that it is productive of very severe lung lesions. We are beginning to discover cases in this country. Not only in smelting ores containing cadmium, but in making alloys and in welding alloys, and in cutting cadmium-plated metal with oxyacetylene flame; in electro-plating. So far no cases have appeared in the paint industry, but the danger must be present in the making and spraying of cadmium yellow and cadmium orange paint. Cases of recognized poisoning are very rare but of course we all know that that does not mean that they are actually rare. A case of acute, severe and rapidly fatal pneumonia in a workman in a foundry might not lead the physician to expect any connection with cadmium fumes.

The most recent cases came from the Public Health Service. Thus, Nasatir reported a death which occurred on the fifth day after exposure to the fumes caused by an acetylene flame, playing on cadmium-containing metal. Then the Ohio Bureau of Occupational Hygiene of the Health Department reports two non-fatal cases. The Indiana Bureau of Occupational Hygiene reports two cases, one fatal, in men using a blow torch on cadmium-plated steel pipe. In 1938 Rothwell and Frankish reported fifteen cases with two deaths. Dr. R. T. Johnstone of Los Angeles has a very interesting detailed description in his book of a case of fatal cadmium poisoning in a man using an acetylene torch on the inside wall of a rotary furnace in which cadmium residues had been worked up. The action shown in man as in experimental animals is chiefly on the lungs, the other effects are apparently unimportant. It resembles metal fume fever in its early symptoms; it resembles nitrous fume poisoning in the later stage, with acute congestion and edema of the lungs followed by death, or, if the case is less severe, by pneumonia.

* * *

Magnesium fumes, we know cause metal fume fever. But we are only now beginning to hear about occupational gas gangrene from magnesium. Dr. McCord has seen many cases of gas blisters in magnesium workers who get a bit of the metal under the skin. Analysis of the gas showed nothing worse than the constituents of the air, nitrogen, H^2 and O^2, but the lesions are often pretty serious. Apparently the presence of the particle of metallic magnesium under the skin causes the formation of these gases with blisters more or less severe which may or may not go on to ulceration or gangrene. They have had the same experience in English factories. Physicians who have seen these cases advise very strongly a careful removal of all the particles of metallic magnesium which may get into a scratch or cut. McCord produced typical lesions experimentally in animals with metallic magnesium.

* * *

A quite new poison (and we do not yet know if it really is one), is beryllium. Beryllium seems to be a very valuable constituent of one of the steel alloys. The Russians have been writing about beryllium poisons for some time. All of our information came from Russian authorities up to very recently. They attribute to the dust of the fluorine compounds of beryllium an irritating action on the skin and on the mucous membranes, and metal fume fever to the fumes in the extraction of beryllium. This last, according to the Russians, is sometimes followed by actual pulmonary inflammation with an x-ray picture resembling acute miliary tuberculosis. However, Fairhall, of the Public Health Service, has made a very exhaustive study of beryllium and says it is not toxic, and the effects noted by the Russians are to be attributed to the fluoride compounds and not to the beryllium itself.

* * *

We have a new coating that has come into use and I cannot tell you how much it is used but it is considered a valuable coating for porous building material, stone and plaster and stucco and such. This also has been studied by McCord. It is an organic silicate, tetra-ortho-silicate, a jelly-like compound. McCord finds if you inject it in animals, the lesions, the typical lesions, appear in the lungs and of course still more if the animal breathes a spray. We have no data at all on effects on man.

* * *

Then there is the new industry of synthetic rubber which has brought in new problems, although not as many new ones as we expected, because once the rubber has been produced, the solvents are much the same as those for natural rubber. The same groups of compounds, accelarators, plasticizers, anti-oxydants are used so that the really new features that have been brought in are in connection with the production. The first rubber that we made you will remember was neoprene, the oldest variety, made from acetylene and acetylene is of very dubious toxicity. Cases of injury from acetylene poisoning have usually been traced to an impurity because there are some serious possibilities there. Impurities may be phosphoretted hydrogen or arsine, or hydrogen sulphide, but acetylene itself is considered harmless. However, chloroprene, a stage in the production of neoprene, is chlorobutadiene with the toxic action that chlor compounds have, on the liver and on the kidneys. Also it causes hemolysis and a sharp fall in the blood pressure. All of these facts come from study on animals, no such observations have been made on men.

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The most important, of course, are the buna rubbers and in connection with these we have three substances to pay attention to, butadiene, momomeric styrene and acrylonitrile. Butadiene has been studied very carefully. It is a gas at ordinary temperatures so it has to be kept under pressure, which means that good engineering will make the premises safe during ordinary procedure, but accidents and repairs will have to be dealt with. One cannot assume that there is no danger at all. So far, all that has been observed in workers is a mild narcotic action. It is possible that there might be enough fumes in the air to cause, not actual intoxication but enough to cause "dopiness"—there is no better word than that—to bring about an accident. However, we have nothing more serious to say about butadiene at present than that it is a mild narcotic. Of course you can kill animals with it but you have to give them a very big dose.

Spencer and Cole of the Dow Chemical Company have made a very careful study of styrene. They find it is acutely dangerous at 24 hundred parts per million, that immediate death in animals is caused by a direct effect on the central nervous system and delayed death by pneumonia. In man all that has been noted has been extreme eye and nose and throat irritation, which comes on when the concentration reaches 1300 parts per million. They advise that the maximum allowable concentration be kept down to 400 parts per million, at which point there is a disagreeable odor that can be easily noted, but there is no danger.

Acrylonitrile is a different thing. It is a cyanide, with the typical cyanide action. It is a poison to the central nervous system and causes changes in the hemoglobin which result in what we call internal strangulation, a sudden, complete anoxemia which may cause rapid death. But there is also a direct effect upon the central nervous system. In man all that has been noted so far are the early symptoms of anoxemia, flushing of the face, rapid breathing, rapid pulse, and also an irritation of eyes and nose which last may serve as a valuable warning symptom. In animals it has been found that sodium nitrite will increase the resistance because it forms methemoglobin which combines with the nitrile molecule and removes it from the blood.

Thiokol, the third form of artificial rubber, is made by condensing polysulfides with a chlorinated hydrocarbon, usually ethylene dichloride. This means the danger of escape of sulphuretted hydrogen, H^2S, the danger inherent in the use of ethylene dichloride.

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Those I think are the principal new dangers that have come in the course of the war. I know that many of you had experience through the last war but I do not believe any of you had the peculiar experience that I had which makes me look upon an audience like this with real wonder when I think back to 1917 and 1918. For there had never been a meeting of the American Medical Association to discuss industrial medicine. There had never been, as far as I know, an article on the subject in the *Journal of the A.M.A.*—well, perhaps one—I remember one on lead poisoning but that was about all. Nobody cared about it. Nobody was interested. The Public Health Service had nothing to do with industrial medicine. It was not considered a public concern. During the first World War, a little committee of eminent doctors, among them Richard Pearce and David Edsall, tried to do something about the protection of men in war work but met with no response. Organized Labor was contemptuous about what happened to men who had not sense enough to form a union. The medical profession knew nothing about munition poisons. When you tried to urge prevention on the men of the Army and Navy, they said, "For Heaven's sake, think of our men in the trenches and you talk about fumes!"

So we did not talk about fumes, for nobody would listen. Now, it is so very different that I cannot help hoping for great things. The first war gave industrial medicine a great boost forward. I think the second is going to push it on still further. It is a comfort to think of one good thing coming out of this ghastly mess.

Hadlyme, Conn.

HORMONES AND THE SKIN*

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HORMONES are definite chemical substances which are secreted by certain specialized cells of the body and enter the blood stream, and have a controlling influence on other cells in distant parts of the body. To a certain extent, they are controlled by the autonomic nerve system, and their integrity is dependent on an adequate supply of vitamins. Heredity, however, is the chief factor in their proper function and balance, as well as the chronology of their activity and subsequent necrobiosis.

There are some facts which seem to indicate that the thickness, elasticity, texture, color and blood supply of the skin have some direct relation to the estrogenic and androgenic hormones, and that these are governed by other hormones, especially by the hormones secreted by the pituitary. It is also a fact that certain skin abnormalities are caused by glandular dysfunctions, and that many of these are caused by malfunctions of the autonomic nerve system.

It is a well known fact that the pregnant female of all mammals has an excessive supply of estrogenic hormones, and that the new born from that female also has an over-average supply of female hormones which is derived from the mother, and that, as a consequence, the Wasserman test is identical with that of the mother for the first few weeks. Later it becomes specific for the child. Another change is in the vaginal canal. At birth the vaginal mucous membrane is lined with ten or twelve layers of cells, and within a few weeks this area becomes thinner, and is composed of only two or three layers of cells, and remains at about the same thickness until near the age of eight, when the estrogenic hormones begin to be secreted in larger amounts, and the vaginal mucous membrane becomes thicker and remains at about the same thickness until the menopause. It is during the time when the vaginal mucous is thin that children are susceptible to gonorrhea, and post menopause women are apt to have intractible itching, and both of these conditions are improved by the local application of estrogenic hormones which causes thickening of the vaginal mucous membrane. This correlation between the thickness of the vaginal mucous membrane and the amount of estrogenic hormones is the basis of pregnancy tests by the use of animals.

RELATIONSHIP TO CHANGES IN THE SKIN

Before puberty, the skin of a male and a female child shows little difference in appearance or anatomy. There is, however, a considerable difference in hydrogen ion concentration between a child and an adult. Before puberty, the Ph of the skin varies between 6.2 and 6.4. After puberty, it is definitely more acid and the Ph is between 4.5 and 5.6. This lowered alkalinity is sufficient to retard or prevent the development of certain tenia infections which are notably prevalent in children, and do not ordinarily occur after puberty. Androgenic or estrogenic hormones are logically and successfully used to cause a higher degree of acidity in the skin, and to thus discourage the growth of those forms of tenia which are prone to attack children only. As the age of puberty approaches, beginning at about eight in a girl and somewhat later in a boy, the secretion of estrogenic and androgenic hormones increases and it is then that the differentiation of the sexes becomes more apparent. Each individual has a mixture of androgenic and estrogenic hormones, being constantly secreted and acting in such a manner as to influence sex characteristics. The proportional amount of these hormones determines which sex predominates as far as the psychological qualities are concerned, and also, to a certain extent, whether the skin is characteristically that of a male or female. Between the very feminine woman and the very masculine man, there is a no man's land, where the anatomical and psychological characteristics are not parallel. This is proved by animal experimentation. In birds, the male has a conspicuous coloring, but these may be modified or reversed by castration or injecting appropriate hormones. If the ovary of a young bird is removed, brilliant plumage and capon characteristics develop.

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* Chairman's Address. Read before the Section on Dermatology and Syphilology at the seventy-third annual session of the California Medical Association, Los Angeles, May 7-8, 1944.

Just as in animals, the masculinity and femininity of humans are controlled by androgenic and estrogenic hormones, and in adults there are definite differences between the skin of a man and that of a woman. The female skin is more delicate, somewhat thinner, and the vascular control is much more sensitive. In both sexes the increase of sex hormones causes a reduction of the alkalinity of the skin, a condensation of the dermal cells, an increase of the subcutaneous supporting tissues, hyperplasia of all glands of the skin, including the mammary glands, and an increase of the blood supply, the so-called turgor vitalis or "bloom of youth". The apocrine glands of the axilla and pubes increase in size, and the pigment surrounding them is also increased.

Eunuchs and eunuchoid men, as a rule, have a marked pallor of their skin, due to the fact that the cutaneous bed of such hypogonoid men has less blood flowing through it than normal men. The administration of androgens to such persons tends to increase the cutaneous blood supply, and, if administered for a sufficient time, their complexion becomes definitely ruddy. Both androgens and estrogens tend to increase the activity of all sebaceous glands, and estrogens, if applied to the female breast, will usually increase its volume to several times its original size. This procedure is questionable, however, because of the possibility of producing cancer.

ON GROWTH OF HAIR

Sex hormones also have an important effect on the growth of hair. Both sexes have a full growth of hair on the head soon after birth. At the advent of puberty, however, both males and females begin to have hair on the pubes and in the axilla. The pubic hair is slightly different in the two sexes. That of the woman does not extend so high on the pubes and its upper border extends straight across. In the male, the upper border extends toward the umbilicus and is pointed upward.

Castration before puberty, as performed by a Russian sect on all boys, has a characteristic effect on the growth of hair. These boys all have a thick growth of hair on their heads, and well-developed, but not bushy eyebrows. They have no beard when they are young; but when they get old, they have a coarse growth on the chin and upper corners of the mouth, but have no hair on their body or limbs. They have scarcely any axillary hair, and their pubic hair has a straight upper border as in a woman. Castration of males in full maturity is followed by a thinning of hair on the face, pubes and body. Castration of adult women is usually followed by a thinning or loss of pubic and axillary hair.

Male homosexuals have an abundant growth of hair on the head, and are not apt to get bald as they get older. Conversely the bald-headed men, who have a tendency to sit in the front rows of musical comedies, are well endowed with androgens. Bald-headed women are very rare, and are apt to have some abnormality of the adrenal gland which seems to cause an increase in androgenic hormones. Conversely, women who have an excess of hair on the face have been known to lose that hair after estrogenic hormones have been applied. It is a curious fact that hair on the outer side of the lower leg disappears at about the same time that it does from the head, while homosexuals retain that hair indefinitely. That this loss of hair is not due to the rubbing of the clothing is proved by the fact that Scotchmen who have never worn pants have the same alopecia.

Pregnancy places a great strain on the metabolic mechanism of a woman, and various toxic manifestations often occur during that period. This is because the liver, kidneys and reticulo-endothelial system are not fully functioning. The reticulo-endothelial system is particularly concerned with this, and the more histiocytes there are in the epithelium, the less liability there is to these septic rashes. Also, the greater the amount of estrogenic hormones, the greater the amount of histiocytes there is in the epithelium, and so septic rashes are less liable to occur in those women who have a generous supply of estrogenic hormones. The number of histiocytes in the epithelium is determined by the rapidity with which congo red is distributed in the epithelium. This mechanism also accounts for the prevalence of septic rashes after castration and after menopause.

SKIN CHANGES IN ADULT LIFE

After middle life, the amount of estrogenic and androgenic hormones begins to diminish, and the skin of old age begins to appear. This aging of the skin appears later in men than in women, much later as a rule. The first change is one of dehydration and atrophy, especially of the cutaneous bed. The skin becomes withered and scaly and sometimes shiny. There is less of the turgor of youth and the color is more grey. The underlying and supporting tissues shrink, and because of that shrinking, and also because of the stretching of the epidermis, wrinkles develop. As a result of this shrinking and also because of a diminished blood supply, there is deposited in the epidermis more pigment than in youth, and the skin becomes diffusely brown, and in those who have little natural pigment it becomes grey and pasty. In women, hair grows on the face, and finally male and female skin are nearly identical in essential characteristics.

Histologically, the atrophic skin of old age is characterized by atrophy of the prickle cells of the malphigian layer and, although the basal layer has lost most of its vitality, it is still capable of storing pigment, which it does in excessive amounts. The corium is greatly atrophied and the collagen degenerates into collasten. The absence of supporting tissue causes the papillae to be obliterated, and there is a flattened epidermal dermal junction.

THYROID AND PITUITARY SECRETIONS

Although the sex hormones have a major rôle in the physiology of the skin, the thyroid also has an important influence. A deficient thyroid secretion causes the skin to feel dry, rough and scaly. In excessive deficiency, there is deposited in the skin a mucoid substance which does not pit as does oedema, and this gives a dull and stupid appearance to the face. The scalp and hair are dry and poorly nourished. The eyebrows are thin, especially at the outer ends. The nails are rough and brittle.

In excessive thyroid secretion, the skin is warm, moist and flushed, especially on the face and chest. Pressure leaves a pale place which remains colorless for several seconds. Dermographia is often present, and excessive sweating is common. Pigmented spots are often present on the hands, face and neck. In a general way the amount of thyroid secretion is correlated with the basal metabolism.

The functions of the pituitary gland are so far reaching, and so closely tied up with the other glands that it might well be the subject of a book, and only the most casual reference to its rôle as the leader of the band can be given at this time. Malfunction of the anterior pituitary teamed with the pars intermedia of the adrenal is associated with abnormal pigmentation, and sometimes with androgenic increase, which occasionally causes masculinization in women. Deficient secretion also may cause brown pigment, resembling freckles, and if there is a definite deficiency, as in Simmonds disease, there is a general atrophy of the skin and all other tissues, as in old age.

Numerous early investigators maintained that hormones have an important influence on the prevention of the ravages of age, and it was thought that rejuvenation could be brought about by increasing the supply of estrogenic or androgenic hormones; but this view has not been entirely upheld by subsequent investigators. It has some degree of truth, however, because sex hormones do retard some of the degenerations of the skin and, as a general rule, when there is a more youthful skin than the chronological age would warrant, the androgenic or estrogenic secretion is found to be higher than normal. There always exists a factor in the substratum which limits the extent of the hormone activity, and this is controlled by heredity. So, therefore, hormones can only accentuate or retard the natural tendencies of the individual.

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Wilms Tumor (Embryoma of the Kidney)

Max Wilms (1867-1918), while *Privat-dozent* in surgery at Leipzig under Trendelenburg, published in 1889 the first volume of a comprehensive trilogy "Die Mischgeschwülste [Mixed Tumors]" (Leipzig, 1902). The title of the first volume is "Die Mischgeschwülste der Niere [Mixed Tumors of the Kidney]." A portion of the translation from page 83 follows:

"I . . . am satisfied that as a result of the present treatise I have been able to widen our understanding of the structure and growth of mesodermal kidney tumors, and with the support of solid embryologic facts, to demonstrate their origin from definite cells derived from and corresponding in their characteristics to the mesoderm of the midportion of the body."—R. W. B., in *New England Journal of Medicine.*

SCRUB TYPHUS

Alfred C. Reed, M. D.
San Francisco

L. E., male, 30, an aviator, had been for 18 months in the South Pacific, visiting various islands outside the general area of known scrub typhus endemicity. He had been in poor health for some months.

REPORT OF CASE

Present Illness. The patient was hospitalized in the Pacific area for suspected cholecystitis with achylia. X-rays of the gastrointestinal tract and gallbladder were negative. Two weeks after entering the hospital, he developed a tender swelling above the right elbow in the region of the epitrochlear gland. He had had previous to this, for an uncertain time, a lesion on the terminal phalanx of the middle finger of the right hand. His temperature rose to 99°-100° F. daily. Four days after appearance of the enlarged gland above the right elbow, the corresponding axillary glands enlarged, becoming tender and accompanied by redness, and swelling around the epitrochlear gland, with red streaks extending below the elbow and slightly above the region of the inflamed gland. He had a sensation of tightness and aching in both groins and in the right testicle. He had never had malaria. A tentative diagnosis was made of filariasis, although no microfilaria could be demonstrated.

The patient arrived in San Francisco on May 13th, and on May 20th was hospitalized in Mary's Help Hospital.

Examination, on May 13th, was normal, except for the following points. The liver descended 2 finger-breadths below the costal edge, and there was tenderness in the gallbladder area. There was considerable enlargement of the right epitrochlear and axillary glands, with extreme tenderness and much overlying cellulitis, no lymphangitis, and moderate redness. There was a lesion on the inner side of terminal phalanx of right middle finger, about 8 mm. in diameter, raised, smooth except for some umbilication, red, not necrotic and with no surrounding inflammation. Temperature rose 1-2° F. in the afternoon and evening. The spleen was not palpable. Filariasis, malaria and cholecystitis were suspected.

Blood count, on May 13th was as follows:—Hgb. (Newcomer) 110 per cent, (18.6g.). Red cells, 5,630,000. Color index, 0.98. White cells, 12,200; polynuclear cells, 73 per cent, of which 63 per cent were mature and 10 per cent were stab cells. Lymphocytes, 18 per cent. Monocytes, 6 per cent. Eosinophiles, 2 per cent. Basophiles, 1 per cent. Kolmer and Kahn reactions were negative. On May 17th the white cells were 9,700 with 65 per cent polynuclear neutrophiles of which: 11 per cent were stab cells, lymphocytes, 29 per cent, monocytes, 5 per cent and eosinophiles, 1 per cent. On May 19th, the leucocytes stood at 13,050 with 53 per cent polynuclear neutrophiles (17 per cent stab cells), 37 per cent lymphocytes. Monocytes, 7 per cent, and eosinophiles, 3 per cent. Twice daily, from May 13th to May 20th, thick-and-thin blood films failed to show microfilaria, malarial plasmodia or other parasites. Icterus index was 10, Van den Bergh reaction was negative, both direct and indirect. Stool specimens were free of parasites and the urine was normal.

The patient was given sulfadiazene 1.0 g. four times daily for 3 days, with no change in temperature or physical findings.

On May 20th, the patient was hospitalized. The preceding day a morbilliform uniform rash appeared over the trunk and extended lightly to the arms and legs. The conjunctivae were deeply injected. The patient appeared acutely ill, apprehensive, alert and nervous. He felt seriously ill.

Examination showed right epitrochlear and axillary glands were enlarged. The small uniform macular rash did not extend to face, palms or soles, and did not become confluent or necrotic. The temperature course was irregular for the week before admission, ranging between 99° and 102.6°. In the second week it gradually began to remit and became normal late in the third week.

Blood count, on May 20 in hospital, was as follows:—Red cells, 5,330,000. Hgb., 100 per cent. White cells, 12,900, with polynuclear neutrophiles, 85 per cent, lymphocytes, 10 per cent, monocytes, 4 per cent and eosinophiles, 1 per cent. Subsequent blood counts were essentially similar. Icterus index was 10. Repeated examinations for malarial plasmodia were negative. No microfilaria were found, including study of thick films at 2-hour intervals, one night. Blood cultures on May 22, 23, and 24 were negative. Blood agglutinations were negative for tularemia, brucella, dysentery bacilli and the typhoids. Heterophile agglutination of sheep red cells by patient's serum was negative (1-56). Several agglutination tests of blood serum against fresh cultures of proteus OX 19 were negative. Agglutination tests with proteus OX 2 were negative. On May 29, fresh culture of proteus OX K gave a positive titer of 1:80 and, 2 days later, of 1:160. Four days after this, the titer was again 1:80.

A few drops of gland juice were obtained from the swollen epitrochlear gland. Cultures failed to show growth. Inoculation of three white mice gave no evidence of illness. The mice remained normal, until sacrificed on the 10th and 14th days after inoculation. Examination by Dr. J. J. Hawthorne failed to show rickettsial or bacterial infection.

COMMENT

Clinical Course. The rash began to recede after 2 days and disappeared in 6 days. The spleen became palpable on May 30th. The epitrochlear gland, after diagnostic puncture, suppurated, discharged for 10 days and gradually healed. Clinical improvement accompanied the lytic fall of temperature, and the patient left the hospital on May 31st. He was feeling normal except for considerable prostration. In the subsequent 2 months he regained his normal weight and strength.

Treatment was symptomatic, using aspirin, codein, cool sponging and, one period of 3 days, of sulfadiazene when secondary bacterial infection was feared. Epsom salt compresses and, later, alcohol-glycerin compresses were used on the suppurating gland. Special attention was given to a high caloric diet and excess vitamins in general. Sedatives were necessary for sleep.

Diagnosis. 1. Mild subacute cholecystitis.

2. Scrub typhus.

This diagnosis rested on:

(1) recent presence in an endemic area with fairly close contact with rats (hence the probability of transfer of larval Trombiculae from rat to patient);

(2) the clinical picture of primary lesion (but not necrosing), injected conjunctivae, severe subjective symptoms, fever ending by lysis, characteristic rash, proximal lymphadenitis, and enlarged spleen;

(3) positive OX K agglutination with negative OX 19 and OX 2, and elimination of diagnoses of plague, tularemia, and malaria. Filariasis could not be excluded certainly as a concomitant diagnosis.

The atypical features were the absence of leucopenia, the nonnecrotic primary lesion, the apparently long incubation period (uncertain, probably three weeks or more), the absence of pulmonary involvement and deafness, and the suppuration of a gland (this may have been precipitated by diagnostic gland puncture). However, suppuration occasionally is seen in scrub typhus and increases the resemblance to plague bubo.

Conclusion. Imported cases of scrub typhus may be seen at any time, anywhere in the United States.

350 Post Street.

WAR ANESTHESIA IN THE SOUTH PACIFIC*

Lt. Commander Edwin Hal Kelley
MC-V(S), U.S.N.R.
San Diego

BEFORE presentation, it was necessary to have this paper censored by the Navy Department; consequently, statistics will be limited, as action is, and will be going on in the South Pacific for some time.

The purpose of the paper is to show you, if possible, how difficult and unsatisfactory anesthesia is away from the modern operating room, and to let any Service-connected individual in this audience know what to expect should he be sent into the war area. Several weeks have passed since these experiences, but anesthesia has not yet been, and cannot be altered to any extent.

Our organization was a so-called Mobile Base hospital—*mobile*, because we brought all of our equipment with us and set up the hospital ourselves; *base*, because, once set up, it cannot easily be moved. Each doctor was given a crew of men and set to work putting up the prefabricated steel buildings; our job was to lay down the wooden floors. When you consider that this hospital had 1,000 acute, and 2,500 ambulatory or convalescent beds, you have some idea of the amount of boards and nails we used. Long before the unit was completed, patients began arriving, so that it was often necessary to leave the construction and rush to the surgeries which were built first. We often worked by lantern light to complete a building in order to get more wounded men in out of the weather. In all the times it was necessary to awaken and bring out my crew, but not once did any fail to show up or grumble about being tired. Absenteeism was unknown; the working day any or all hours of the twenty-four, with a seven-day week. Some of our war industry employees might take a lesson from these boys.

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* This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the U. S. Navy. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the Navy Department, or the military service at large.

The hospital was set up within easy bombing range of the Japanese base at Bougainville, and our patients were brought in by ambulance plane, transport and hospital ship. Because we had to depend largely on corpsmen to give the anesthetics, my district medical officer directed me to organize a pattern of anesthesia suitable to our base hospital, the advanced dressing stations on Guadalcanal and the operating rooms of the transports. One system was used to facilitate teaching, because today a man might be at the base and tomorrow at a field hospital. As a result, anesthesia was uniform over the entire area.

Gas—nitrous oxide, ethylene, helium or cyclopropane—we did not have any provisions for getting cylinders either from Australia or the States. We did have a machine which the supply officers assured me was a Heidbrink, so that all of the spare parts from my own machine were brought along. When it was unpacked it was found to be a McKesson of the type probably used at Gettysburg.

Ether was frowned on because it is inflammable, and nothing of the nature was permitted. In fact, all paint, linoleum, and such accessories, were disposed of, due to the hazard of fire from a shell or bomb explosion.

Chloroform, yes; but when we unpacked it, it turned out to be a Barred Parker solution.

All of which simmers down to what could be used, namely—the three types of anesthesia—spinal, local, and intravenous, with various combinations of each. By going through all of the surgical supplies we found some Pilling silver continuous spinal needles, but no one-way syringes or mattresses for same. The American sailor is a resourceful individual, so when we told the mechanics in the gear locker what was wanted, they rigged up a one-way syringe by means of a ball-bearing taken from a junked plane and a pad made from three narrow mattresses, covered with canvas and a notch cut in the side. Crude, but extremely serviceable, and from these models many others were made.

Pentothal sodium was easier — we simply started intravenous glucose or saline, and added the pentothal in 5 per cent solution until the desired depth of anesthesia was obtained. Many of the patients were in shock; thus two purposes were served. The only disagreeable feature is that all litter bearers are equipped with morphine surettes and think nothing of giving a grain or more if it was felt the patient needed it. Oftentimes only 2 or 3 c.c. of the 5 per cent solution were needed after such a heavy dosage of morphine.

A bombing or shelling might be going on at the same time as surgery; so, to prevent the needle being jarred out of the vein, we devised a canvas sleeve into which the patient's arm was placed, and an opening through which the syringe and needle were secured. On numerous occasions it was impossible to find a vein due to the exsanguinated condition of the patient. In these cases, we injected the glucose, plasma and whole blood directly into the corpus cavernosum of the penis. It's surprising how few sloughs we got.

Local anesthesia was used whenever possible.

All patients had been liberally subjected to sulfanilamide in dosages far above those used in the States. It is my understanding that some experimental work is now being done on the hazards of novocaine and pentothal in the presence of this drug. If this is true, we did not recognize it.

Many had been given atabrine and quinine prophylactically for malaria. It is doubtful if these influenced the anesthetic in any way.

Two anesthetists were assigned to each patient—one to administer the anesthetic, and the other to assist and write up the surgical procedure as the surgeon dictated while performing the operation. In case the patient was evacuated immediately following surgery, a complete record went with him.

Several times we were called to give anesthetics to wounded Japanese. Experience quickly taught us not to entrust this to any of our Marine corpsmen.

It is our hope that, as the war progresses, better methods will be available, because to the wounded soldier, sailor or marine, relief from pain is uppermost in his mind.

1205 Medico-Dental Building.

AN OUTBREAK OF SHIGELLA NEWCASTLE DYSENTERY*

Major Victor G. Rubenstein, M.C.
and
Lieutenant R. L. Phillips, Sn. C.
Medical Corps, Army of the United States
Camp Haan, California

THE prompt recognition and the institution of appropriate measures for the control of bacillary dysentery, as for other infectious diseases, are becoming more essential during wartime because of the inevitable crowding of troops and civilians in areas where modern sanitation may at least temporarily be lacking.

The relatively recent use of more selective bacteriological media has increased the laboratory diagnoses of bacillary dysentery. Of greater importance to the military and public health is the increasing awareness among medical officers and civilian physicians that outbreaks of "mild diarrheas," "gastro-intestinal upsets," and "food poisoning" may truly have as a common etiologic agent a species of the Shigella genus of bacteria.

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* From the Laboratory Service, Station Hospital, Camp Haan, California.

This article has been released for publication by the Review Branch, War Department Bureau of Public Relations. The opinions and views set forth in this article are those of the writers and are not to be considered as reflecting the policies of the War Department, or the military service at large.

That only the severer cases of bacillary dysentery have gross blood and mucus in the stools has been recognized by authorities.[1] Probably not more than 2 per cent of bacillary dysenteries occurring in our troops are recorded as bacillary dysentery.[1] The others, because of mildness of the clinical picture or unavailability of an adequate bacteriology laboratory in the field, have been termed "enterocolitis, acute" or "diarrhea, acute, mild, cause undetermined."

A relatively small outbreak of mild bacillary dysentery occurred among troops bivouacked on a Southern California desert area during the late summer of 1943. The cases appeared sporadically at first, not explosively as is characteristic of food poisoning. The hospital admission rate reached its peak seven days following the appearance of the first case, and abruptly fell thereafter coincident with and presumably because of the improvement in those sanitary measures long recognized by the army and public health authorities as essential for the control of enteric diseases.

Between the 20th and the 24th of September, 1943, bacteriological examination was made on the 78 patients then hospitalized. A single rectal swab taken of each patient was used to streak SS or desoxycholate agar plates and to inoculate a tube of tetrathionate broth. The tetrathionate broth tubes were used after 18 hours incubation to streak the selective media in cases where no suspected colonies were obtaind by the initial plating. A single suspected colony in each case was inoculated in Russel's double sugar and transported to a central laboratory where identification was made by the usual sugar fermentations and by agglutination with immune sera.

Thirty-four positive cultures were identified as Shigella newcastle (Flexner VI), an organism not previously reported in this area.[2] Shigella sonne was found in two cases, and a single infection with Salmonella schotmulleri was found.

While Shigella newcastle has been known to produce as virulent a disease as commoner Shigella organisms, the majority of the cases in the current outbreak were classified as "mild," recovering uneventfully without specific treatment within one to four days. No gross blood nor mucus was observed in the stool of any patient. An inflammatory exudate, however, was seen microscopically in all cases examined.

The hidden hazard of a clinically mild outbreak of bacillary dysentery should not be overlooked. Failure to determine promptly the true etiology, with the consequent failure to isolate patients, will result in undue contamination of latrines, of soil, food and water with pathogenic organisms which are as contagious as any of the Shigella group. Thus will result a wider spread epidemic with more men infected, though less severely, than in those epidemics of severer, "classical," dysentery infections.

CONCLUSION

An epidemic of mild, bacillary dysentery, due principally to Shigella newcastle (Flexner VI), and its prompt control by correction of sanitary defects, illustrates the necessity for immediate correct laboratory diagnosis in any outbreak of enteric disease, regardless of the clinical severity or whether gross blood or mucus is present in the stool.

Station Hospital.

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2. Personal communication: Kessel, John F., University of Southern California School of Medicine, Los Angeles, Calif.

DERMATITIS OF THE FEET AND HANDS DUE TO RUBBER

C. Russell Anderson, M. D.
Los Angeles

Every physician is familiar with contact dermatitis of the feet due to sensitivity to leather and stocking dyes and stocking finishers.[1] That dermatitis of the feet may be due to a rubber sensitivity is a little known fact and is of great practical importance. I have been unable to find any reference to rubber dermatitis of the feet in the literature, and I have found that most of my dermatologic colleagues also are unfamiliar with it.

Rubber dermatitis of the feet most often affects women, as rubber is used extensively in the manufacture of women's shoes. Rubber cement is used for basting various layers of the shoes during the sewing process, and for fastening down the sock liner to the inner sole. In addition, an elastic rubber fabric is used frequently as an inner lining of the uppers of suede shoes to give a smoother and snugger fit. Rubber dermatitis of the feet is less commonly seen in men, as their shoes are built more sturdily and the sock liner is heavier.

Signs.—The dermatitis may be manifested by erythema, edema, vesiculation, weeping and crusting. It may involve any part of the foot in contact with the rubber fabric or rubber cement. However, it most frequently appears first on the toes, as the sock liner at the toe of the shoe often becomes loosened and the lining of the box of the toe is worn through early. The sides of the heels are also early sites of the dermatitis as the lining of the counter is easily worn through.

Diagnosis. — Rubber dermatitis of the feet should be suspected when the patient has had a previous dermatitis from rubber girdles, dress shields and unprotected garters. Therefore, a careful history must be taken. However, I have attended women with rubber dermatitis of the feet who did not wear dress shields or girdles. There may be confusion with acute dermatophytosis of the feet, especially if the patient develops a vesicular eruption of the hands. However, as Baer[2] has pointed out, "it is not generally recognized that contact-type eczematous eruptions on the feet—of *nonfungous* etiology—in some cases produce eczematous eruptions on the hands, and that, conversely, contact-type eczematous eruptions of the hands occasionally produce vesicular eruptions of the feet." Incidentally, physicians suffering from an eczematous dermatitis of the hands and feet are occasionally subjected to futile treatment for dermatophytosis when actually suffering from surgical glove dermatitis and rubber dermatitis of the feet. The physician may have accepted a negative test patch to rubber performed on the arm or on another site distant from the hands, forgetting that the sensitivity to the rubber glove may have been strictly localized to the hands. Sensitivity to rubber gloves should not be ruled out until patch tests have been performed on the back of the hands. The best way to do this is to have the physician wear the suspected rubber glove over a cotton or silk glove in which a small hole has been cut in the back. A positive diagnosis of rubber dermatitis of the feet is made by patch testing with pieces of leather or fabric with rubber cemented surfaces placed directly on the skin.

Treatment.—The treatment of the condition is obvious. Yet, it is difficult, especially for women, to buy shoes in which exposure to rubber can be eliminated. I have found it wise to refer the patient to a reputable shoe dealer who sells both factory and custom built shoes. He can often select a shoe in which there is no rubber in the uppers and replace the sock liner. This may suffice when there is but mild sensitivity. When a high degree of sensitivity is present, there is no recourse except to purchase custom built shoes in which all rubber has been eliminated.

SUMMARY

Sensitivity to rubber should be considered in looking for the cause of a dermatitis of the feet.

1930 Wilshire Boulevard.

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DIABETIC COMA*

Hugh Stephens, M. D.

and

Lt. Commander H. I. Burtness (MC), U.S.N.R.

Santa Barbara

We wish to report a case of diabetic coma with recovery in which the blood sugar was unusually high, and in which an unusually large amount of fluid was administered parenterally without evidence of overloading the circulation.

The patient entered the hospital with an initial blood sugar level of 1,550 mgm. per cent. Joslin[1] reports 17 cases of diabetic coma in which the initial blood sugar was 1,000 mgm. per cent or above. Of these 12 recovered and 5 died. The highest blood sugar with recovery was 1,680 mgm. per cent. He quotes Dillon and Dyer who reported 25 cases with an initial blood sugar of 1,000 mgm. per cent or more. Of these 9 recovered and 16 died. Recovery took place in a woman with a reading of 1,850. Lawrence reported a blood sugar of 2,060 mgm. per cent with fatal termination.

Within the past year, Greenberg and Rhodes[2] have reported a case in which the blood sugar rose to 1,600 mgm. per cent despite continuous insulin treatment. Following further intensive insulin therapy there was final recovery.

Recovery from diabetic coma with a blood sugar as high as 1,550 mgm. per cent is then relatively rare.

A further interesting observation in this case was that a total of 11,500 c.c. of intravenous fluid was given in a period of 24 hours without evidence of circulatory overloading. We feel that this amount of fluid was essential to correction of dehydration and to maintenance of the peripheral circulation, and that it was life-saving. In this period 495 units of insulin were given. The total urinary output by catheter in this period was only a few hundred c.c.

Justification of the use of such large amounts of fluid in the circulatory collapse and dehydration of diabetic coma would seem to come from Joslin's report of an "exceptional case" in which recovery followed the administration of 11 liters of liquid in 12 hours (by mouth and parenterally) without any hint of circulatory failure.

Campbell, Reeser, and Kepler are reported to have given a patient 9,875 c.c. of fluid in 12 hours. Root and Riseman gave one patient 13,800 c.c. and another 11,600 c.c. in the first 29 hours of treatment without sign of cardiac failure.

REPORT OF CASE

Mr. A. B., age 60, was admitted to the Santa Barbara Cottage Hospital 7-31-42, at 3:30 P.M., in severe diabetic acidosis. He was not responsive, but did not appear deeply comatose. Admission blood sugar was 1,550 mgm. per cent, CO_2 combining power was 11 volumes per cent, red count was 4,320,000, white count 15,850 with 86 per cent polys, urine sugar was 4+, acetone 1+. No diacetic acid was reported. Blood pressure was 70/30. There was Kussmaul type of respiration. Dehydration was profound. The tongue had an appearance of old, hard leather.

In the subsequent 24 hours there were administered intravenously the following fluids: 3,000 c.c. Ringer's lactose, 5,000 c.c. normal saline, 2,000 c.c. 5 per cent glucose in distilled water, 1,000 c.c. 10 per cent glucose in distilled water, and 500 c.c. of blood plasma. Four hundred ninety-five units of insulin were given. One thousand two hundred fifty c.c. of fluid were retained by mouth.

On the second day the red count fell to 2,940,000 and the white count to 5,900 with 82 per cent polys. The blood sugar fell steadily to 249 the second day with a CO_2 of 44. The NPN rose to 90.

Further recovery was uneventful. Unfortunately this patient died of diabetic gangrene on a subsequent readmission.

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* From the Sansum Clinic, Santa Barbara.

We feel that it should be once again emphasized that death in diabetic coma comes from shock, ordinarily. Death may occur while the blood sugar and CO_2 combining power are both normal. We agree with Wiesel and Cohn and Schecter[3] that adequate volumes of osmotically active solutions such as plasma should be given early and should be continued until blood flow and blood pressure are increased to normal and maintained. We also agree that prompt restoration of blood volume is almost as important as insulin and that, even though lack of insulin be the initiating factor in the series of events leading to the development of diabetic acidosis with peripheral circulatory failure, in treatment measures directed toward restoration of blood volume and adequate circulation should be instituted before, or simultaneous with, administration of insulin.

Our patient was given 500 c.c. of human plasma when, after twelve hours of intensive therapy, the blood pressure remained 60/30 and death appeared imminent.

317 West Pueblo Street.

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CALIFORNIA INDUSTRIAL ACCIDENT FEE SCHEDULE*

Hartley F. Peart, Esq.
San Francisco

In view of the necessity of conserving time at this session, I would merely refer to our report for the year printed in the "Pre-Convention Bulletin" of the April issue of California and Western Medicine, were it not for the fact that there is one item,—the fee schedule of the Industrial Accident Commission, that is of such importance as to demand a brief supplement. . . .

The fee schedule, as enforced today, was adopted by the Industrial Accident Commission in 1920 and became effective the first of June of that year, 24 years ago. It was a poor type of schedule, listing only 87 procedures and operations as against 543 procedures and operations falling within the jurisdiction of compensation, being the fee schedule adopted in 1913, nearly 30 years ago, with a 25 per cent raise in 1920, 24 years ago. The costs of physicians' instruments and appliances, rents and assistants, secretarial help and his education were far less then than they are today. Benefits under the Compensation Act were also very much lower than they are today. Medical practice has made great advances in these 24 years.

The Association's application for a fair, adequate and compensatory fee schedule, covering the 543 operations and procedures embraced within this practice, was presented to the Commission during a public hearing on February 15, 1943, over 14 months ago. Under the direction of the previous Commission it had been reviewed by Dr. Harbaugh, Medical Director of the Commission, and it was presented with his approval. Later, the Commission, in a letter to Dr. Gilman, Chairman of the Council of the Association, said:

"If you could, as Chairman of the Council of the California Medical Association, undertake some fundamental and long-range program whereby uniform rates of medical fees are demanded and adhered to by the medical profession, with the necessary machinery for disciplinary action for infraction, etc., I feel that progress could be made, and our objections (to granting the application) may be largely overcome."

As set forth in our report, a canvas of the entire membership was undertaken by the Council. Between 75 and 80 per cent of the members, as well as non-member, practicing physicians, signed pledge-cards agreeing to adhere to the fee schedule as fixed by the Commission and to the ethics prescribed for this practice. At the close of last year, Dr. Gilman was able to notify the Commission that Mr. Scharrenberg's suggestion had been carried out.

Later, and since our report was submitted for publication in the "Bulletin," the Commission has appointed a committee consisting of physicians to examine the fee schedule, and to satisfy them on the attitude of the profession in the matter of enforcement of the rates established by self-discipline within the ranks. We know that the report of this committee made some weeks ago to the Commission was a favorable one. The Medical Advisory Committee of the Bureau of Vocational Rehabilitation of the Department of Education, we are reliably informed, is favorably considering the recommendation of the adoption of the schedule proposed for compensation work as the schedule of that Bureau. On March 28th last, Dr. Gilman wrote the Commission, requesting a decision so that such a decision could be reported to the members at this session. Dr. Gilman said:

"I need not review the various steps that have been taken by the Association either voluntarily or at your request since this application was filed. The records are clear on all of these points, and it is our sincere belief that we have taken all steps necessary to merit the favorable consideration by your Honorable Commission on our application.

"May I again request that your Honorable Commission come to a decision in the near future on the requested schedule of fees so that a decision may be reported to our annual session?

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* Address of Hartley F. Peart, Legal Counsel of California Medical Association, to C.M.A. House of Delegates, May 7, 1944, at Los Angeles. See also report in Pre-Convention Bulletin, California and Western Medicine, for April, 1944, on page 166.

May I also respectfully express the hope that your decision may be such as to convince the physicians and surgeons of California of the fairness and justice of your action."

From the date it was filed, the Association's application has been bitterly and persistently fought by some insurance carriers, particularly the State-operated carrier, the State Compensation Insurance Fund and its management. The argument of some companies has been that to increase medical fees would require an increase of rates. This argument is not true and is unsound. Strangely enough, no accurate statistics are kept on physicians' services. It is lumped in with the medical, and then the medical is combined with compensation, and this figure is all included in "losses." There is no breakdown of the medical.

Another practice apparently has become established, namely, that mutual insurance companies must be in a position to rebate back to their insured a substantial portion of the premiums paid by the insured. This runs into millions of dollars annually so far as the State Fund is concerned. The validity of the argument of these insurance companies that the reasonable increase requested would necessarily mean an increase in rates is answered by a decrease ordered by the Insurance Commissioner, in the base rate of compensation insurance of 8 per cent. In response to our inquiry, Commissioner Garrison replied as follows:

"Dear Mr. Peart:

Confirming our telephone conversation, I am enclosing for your information a copy of the order made in connection with the reduction of minimum rates for Workmen's Compensation Insurance. For your information this reduction resulted from a survey of *close* experience, not only in California but throughout the United States. This survey indicated that the Workmen's Compensation losses experienced for the years 1941 and 1942 were within 11 and 12 per cent less than the provision for them in the rate. Having this in mind, we reduced the minimum rate 8 per cent and provided for the elimination of the overtime surcharge as an item in the premium. It is estimated that the elimination of this overtime charge will result in a two or three per cent additional reduction in the compensation rate.

(Signed) Maynard Garrison,
Insurance Commissioner of
California."

The Committee, consisting of Dr. Cass of Los Angeles as Chairman, Dr. Frank McDonald of Sacramento and Dr. Carl Hodge who prepared the proposed fee schedule, has rendered valuable aid from time to time to the Committee charged with the presentation of the schedule to the Commission. This Committee consisting of Dr. Gilman, Chairman, Mr. Hunton and myself has worked very arduously for the past year and one-half on this matter.

I regret that it is necessary to make this report at this time.

111 Sutter Building.

NATIONAL MEDICAL LEGISLATION*

Dwight H. Murray, M.D.
Napa

YOUR speaker has been asked to explain a little more about the United Public Health League, what it is, why it is and why it differs from some other things. I first want to explain to you what the National Physicians' Committee is. The National Physicians' Committee is different from the United Public Health League, and I would like to tell you why. It has nothing to do with informing the Legislature in any way. The National Physicians' Committee is doing a great job on public relations. It is molding public opinion through various newspapers, through editorials, through the radio, and in many and diverse ways.

You have been contributing to the National Physicans' Committee, many of you, and probably all of you, and there is no reason, apparently, why that should not go on.

I have also been asked about Lake County, Indiana, and that plan is entirely different to what we have in mind. If you have read the letter, you will notice that they say there shall be a plan established by which they shall determine to whom and by whom medical care shall be rendered. That I feel we could not support. That is certainly against our ideas of the practice of medicine. The only thing in their plan that anywhere near parallels ours is the opening of an office in Washington for the purpose, as we are doing, of giving information to our legislators.

I hope I have made it clear then why it was necessary for the United Public Health League to be organized. After the adjournment of the California legislature in May we found it apparently increasingly necessary to pay more attention to national legislation.

The Wagner bill for socialized medicine was before us on June 3, 1943. We waited patiently for weeks for word from the American Medical Association as to how we should proceed in combating this bill. No word came, so we decided to undertake our own campaign, realizing how important was such and how much it meant to us. The aid of the Public Health League of California was enlisted. It notified all members of the medical, dental, hospital and allied professions about this bill and aroused them to action. Many of the California Congressmen were home for their summer vacations. These men were contacted by their home doctors and their aid enlisted in opposing this bill. As far as our California men were concerned this was very good and was very effective. We certainly want to thank those people who helped us so well. I especially want to mention the Woman's Auxiliary and the California Bankers Association, through its president, Mr. A. C. Hughes, and their Executive Council, who went through this thing and went all the way for us when they adopted a resolution opposing the Wagner bill. The California Bar Association, through its president, Pat O'Hara, did likewise, so they must feel that there is a lot of danger in this bill if they would go outside their own field to oppose this bill. The Woman's Auxiliary, as usual, have done a very fine piece of work in this connection.

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* Address of Dr. Dwight H. Murray, chairman of Committee on Public Policy and Legislation of California Medical Association, to the C.M.A. House of Delegates, at Los Angeles, on May 7, 1944. For reference in minutes of House of Delegates, see California and Western Medicine, for June, on page 295.

This work continued through the summer. By October of 1943, we still had received no word from the American Medical Association, although I called members of the duly-formed Council and they promised to give me information; but we never could get anything in the way of a program or procedure of what we should do. Incidentally, we have never received any information yet as to how we or any other State should go about combating this particular type of legislation.

The Council of the California Medical Association decided to ask the Public Health League of California for the loan of Ben Read to go to Washington on a prospecting trip. Mr. Read was sent to Washington, in October of last year, 1943, to secure information as to the feeling of legislators and government officials toward the medical profession, to see what one or two allied groups were doing in Washington to protect their interests, and whether or not the medical profession should have an active public office or bureau there for the purpose of giving information to our legislators, and in turn relaying that information back to us. You understand it is our purpose at all times to keep the entire body of the California Medical Association informed of what we are doing. We like to know what is going on in Washington, so we can tell you.

The report of Mr. Ben Read as given to the California Medical Association, excerpts from which were printed in CALIFORNIA AND WESTERN MEDICINE, should leave no doubt in anybody's mind, from the statements of congressmen whom he interviewed, and from all of the experienced political observations he made in Washington, that it was not only apparent but necessary that we have our own representation in Washington. Meanwhile, we have been working with other Western State Medical Societies on united action on the Wagner bill. We felt that we alone, California, could not be heard beyond the Rocky Mountains, but if we could get some other States to join with us, maybe we could all yell loud enough so that our national legislators would listen to us. These other Western States wanted to hear about this. We had our first meeting in Salt Lake City on December 9. The Medical Associations of the 11 Western States were invited to send their Legislative Chairman or other responsible officer to this meeting. The states of Arizona, Colorado, Idaho, Utah, Oregon and California were represented. Nevada, Washington and Montana were unable to attend because of transportation difficulties. At this meeting a temporary organization was formed, known as the Western States Public Health League, with the establishment of a Washington information office as its principal objective. Each State represented at this meeting was to go back to its own Medical Association and ask for approval of the plan. Information about our meeting was sent to all Medical Associations in the United States, as well as to all physician members of the Congress, of which there are seven. The response was excellent, and more than 20 other states voiced approval and encouragement.

The Medical Society of the State of Washington did not have full information, so we solicited an opportunity to meet with the Washington and Oregon Societies to discuss the plan, but received the response that they were not quite ready to go ahead, and we thought probably there might be some particular reason why they were doing this.

The Council of the California Medical Association quickly and unanimously approved the plan authorizing up to $18,000.00 as California's contribution to the expense. At the meeting held in Salt Lake City, on January 29th, a permanent organization was formed and the name changed to The United Public Health League because interest had spread beyond our own Western States. The membership in The United Public Health League now comprises the Medical Associations of Colorado, Idaho, Nevada, Utah, Arizona and California. Dues were set to begin at $3.00 per year. We figured that amount would about cover expenses. The $3.00 would not necessarily be made an assessment, but it would be paid by the various State societies out of their funds. That is about the top of our expenses, and if we get more States into it, our dues would be proportionately less.

The Directors again secured the loaned services of Mr. Ben H. Read on a temporary basis. He was instructed to establish our office in Washington on March 15th of this year, but it was really established on March 14th, of this year. As Chairman of this group of the Western States, I was instructed to appear in Chicago on February 13th at the 18th Annual Meeting of the National Conference on Medical Service. This organization, while not an official part of the American Medical Association, is comprised of leaders of the medical societies of the Middle West who have been meeting for 18 years studying the economic questions of medicine. I asked Mr. Read to go with me and we told them our story. The Conference gave approval to our ideas, but thought the job should be done by the American Medical Association on a national scale. You will recall that, as a result of much pressure for a Washington office the American Medical Association House of Delegates, at its meeting last June, created a Committee of Medical Service and Public Relations. I believe most of the doctors of the country felt that that committee would proceed immediately to represent them in Washington. However such was not the case.

When we became active in the West, and when we presented our ideas at this particular meeting, the American Medical Association Committee on Medical Service and Public Relations suddenly came to life and hastened to establish a Washington office. They met the following day and asked for our appearance before that Committee. As Chairman of the United Public Health League I was very bluntly asked this question, "Would we fold up our plans for a Washington office and get out of the picture if the American Medical Association Council would open a Washington office?" I replied to them that all of our men were members of the American Medical Association. There had been some question about whether or not we didn't represent a left wing and if we were not Reds or something else? We told them that we had been patiently waiting for them to do something since last June, and, instead of it being the order of business at that time, they just let it slide; so we, in February, told them that it should have been their first order of business. They asked me three times, if we would get out of the picture should they open an office in Washington? I told them that if they would go ahead and open an office in Washington along the lines we had suggested (and we had a copy of our principles with us), it to be run in a practical manner by somebody who was not a theorist or college professor, but somebody who had had experience and training in legislative matters, we would then consider it. However, there was very little said to encourage us that they were going to do anything about it in a very practical manner. Finally, I told them that, regardless of the fact that we came from west of the Hudson River, we knew something about our problems of medicine.

Now I want to read to you a resolution that was passed by that Council:

> Whereas, the action of the Council on Medical Service and Public Relations of the American Medical Association in establishing a Washington office of Medical Economics and Research which is to be charged with the collection of information and statistical data concerning medical care, its distribution, its availability, its cost and its control in various parts of the United States, and that the information thus collected be made available to the medical profession through the publication of the American Medical Association to the bureaus of medical economics of the American Medical Association for the study of this problem and to other appropriate agencies interested in the extension of medical service and the provision of medical care and related subjects.

If you could read this resolution, and by the widest stretch of the imagination read into it how they were going to establish from its context a practical office in Washington it would be more than we were able to do. They also appropriated the sum of $1,500.00 a month for the running and maintenance of that office. That, in our estimation, is not anywhere near sufficient to carry on such an office. That resolution was later in the same week passed by the Board of Trustees of the American Medical Association. I finally told them that our office in Washington would be open on March 15th, as we had already promised our people that we would do it. Mr. Read opened that office on the 14th of March and, by some strange coincidence, some official of the American Medical Association happened to be in Washington, and Mr. Read, following our instructions, offered them full coöperation and any assistance he could render.

Understand, we told them we were not doing anything contrary to the American Medical Association; that we were not fighting the National Physicians' Committee; we were not fighting any group or anybody, but that we had our own ideas and our own plans, and we meant to carry them through. That offer has been repeated on numerous occasions. I personally made that offer to Dr. G. Lombard Kelly, Secretary of this Council on Medical Service and Public Relations. I might say that Dr. Lombard Kelly is a very fine gentleman from Georgia. He is Dean of a medical school, but his knowledge of practical legislation is as yet, somewhat limited.

Much has been accomplished in the short period that our office has been opened in the National Capital. Fine coöperation was received from the Medical Association of the District of Columbia, and from representatives of all the allied groups with offices in Washington. The Nurses Association, the Druggists, and the Dentists have done all they possibly could to help Mr. Read in every way.

Our first big accomplishment was interesting Congressman George E. Outland of Santa Barbara in delivering a speech to Congress on what the physicians of California were doing in trying to meet the situation in California through the California Physicians' Service. Mr. Outland was at one time a member of the C.P.S. He made a very fine speech in your behalf. Joining him in the discussion, was Congressman Norris Poulson from your own district here. I hope that you will not forget that Congressman Poulson is up for reëlection and, whatever you do, send him back. Congressmen Holifield and Rolph of California, Dr. Judd of Minnesota, and other veteran observers in Washington, D. C., told us such an accomplishment usually required two or three years work to get over the message that Mr. Outland had put across for us. I want to say here that we do not claim full credit for this, because the physicians from San Luis Obispo and Santa Barbara, the area from where Mr. Outland comes, did a lot in laying the ground work. The response to that speech was excellent from the members of Congress and other interested bodies.

We suggested to the American Medical Association that we follow this up, and have speeches presented from each of the 17 states where there is now a medical service plan similar to what we have in California, so that a record could be built up in Congress to the effect that the doctors of the nation were trying to meet the demands of the public. Then we could say to members of Congress that we can't have this, but we can have a plan of our own, and it is time,—if we are going to get anywhere in our national field,—that we have a plan, and that we get it pretty soon.

To date, the American Medical Association has made no objection to our policies. Our observers tell us that would be the greatest weapon we could possibly have. Our Washington office has been able to develop much information that has been related to all the States which are members of the United Public Health League. Much work that has been done has been through the efforts of our Washington office and the subcommittee of the House Appropriations Committee—which hears the requests of the Children's Bureau on the emergency maternity and infancy care program, about which we have heard so much here in California,—agreed to hear representatives of the medical profession. It was necessary to do some further work to secure this hearing. It is not necessary to tell you all about that now, but Dr. William Benbow Thompson of your own city went to Washington last week, or rather was there on the 27th of April, for this hearing. He will report to you in person about it. I will not attempt to relate here all the things our Washington office has been able to do for you in the six weeks we have been in operation.

I will just quote to you from what two Congressmen, one of them a physician member of Congress, said: "I am glad to know there is some agency ready to function in Washington which will be in a position to bring to the members of Congress the necessary information." The other member of Congress, our own Mr. Poulson, said: "You are now doing something you should have done long ago."

In the latter part of March the Council on Medical Service and Public Relations of the American Medical Association did open their office in Washington.

That brings you pretty well up to date. You have an office in Washington, with a mailing address and telephone listing, but no permanent staff. The question for you to decide is, where do we go from here? We, of course, know what is needed in a practical way. We feel, as other States do, that the American Medical Association should do the job, but from observations to date they are not doing it in a practical way. I will let you draw your own conclusions about whether they are doing it in a practical way, when you hear a little more about what is to be said later on.

As Dr. Kress so ably stated in his editorial this month, "California physicians have had years of experience with public health leagues, and there is a difference between an operative, militant and constructive organization and one of merely well-meaning or the too-convenient type."

Gentlemen, you can't do this job in Washington by token officers. You must have a good contact man. Where would we be in California today if we did not have a contact man in Sacramento? I am afraid we would be practicing medicine under an entirely different plan than we are practicing today, and the same thing applies in Washington. You cannot sit down, in an office, and ask them to come to see you. You have to go to them. We have learned the hard way in California, the work must be carried directly to the Capital, to the bureaus and departments. We feel that it should be done along the lines that have been successful in our own State. All six of the Directors are enthusiastic over what has been done to date, but we cannot continue as a precedent. Mr. Read is needed here in California, and we are going to keep him here at home. He cannot do this job running back and forth between here and Washington. We have now come to the place where we must secure a permanent man for this job.

This situation may come to a crux at the meeting of the American Medical Association House of Delegates in June, but from all information you can gather they will not do the job in an effective and practical manner. I want to say this to the Delegates who go back to the American Medical Association meeting. Don't be lulled by any swan song that this newly-formed Council on Medical Service and Public Relations are going to sing you about the job they are doing in Washington. So far they have accomplished nothing that we have been able to tell of, and don't let them sing you to sleep with the idea that all is going well, and they are doing the job, and you can go home and go to sleep, for such is not the case. You will wake up with a terrible hangover.

How far do the members of the California Medical Association want to go? Many members have told me that they wanted the Washington Office continued even if California has to go it alone. Our biggest fight in Congress is still ahead. It is going to take time to build good and permanent public relations there, and regain the ground lost in recent years. It is our advice, and it is our determination that we are going to carry on with this office in our own way until such time as the American Medical Association decides to do it in the way it should be done. Whether they can do it, whether they know how to do it, or whether they want to do it are other questions, but, believe me, we are going to stay in there until it is done.

I want to say this to you, and I would like to hear some action from this House of Delegates. Congressman A. L. Miller of Nebraska, who is a Past-President of the Nebraska State Association, has been on the job and noticed all of these troubles. He feels there is one way to correct some of your troubles, and I think he is right, and that is to take all medical authority out of the different bureaus. He thinks that the Children's Bureau of the Bureau of Labor should be put under Public Health, where it belongs. He has introduced such a bill before Congress and I should like for this House of Delegates to see fit to write a letter commending Congressman Miller on that action.

Mr. Speaker, I would like to yield the floor to Mr. Ben Read, Secretary of California Public Health League. I realize that it has to be through the unanimous consent of the House before he can address the House of Delegates, but I should like for that to be done. Thank you very much.

Speaker Askey: You have heard the request of Dr. Murray that Mr. Read be given unanimous consent to speak to this House.

. . . It was moved, seconded, put to a vote and carried that Mr. Read be given unanimous consent to speak to the House of Delegates. (Remarks of Mr. Read appeared in California and Western Medicine, for June, on page 295.)

CONTAGIOUSNESS OF SCARLET FEVER

H. O. Swartout, M. D., Dr. P.H.
Los Angeles
and
W. P. Frank, M. D.
Alhambra

FOR some time it has seemed desirable to obtain more definite data as to the contagiousness of scarlet fever under the different circumstances surrounding families in which one or more cases of this disease occur. Conditions in the Alhambra District of the Los Angeles County Health Department have been such as to favor a study being made to collect such data.

Two hundred and fifty consecutive cases that occurred in the Alhambra District from 1939 to 1943 were reviewed. Of the 250 cases, 231 were treated at home. In this group there were 383 susceptible familial contacts from 6 months to 19 years of age. Of the 383 familial contacts, 60 developed secondary cases of scarlet fever. A secondary case was considered as one occurring 48 hours or longer after the original case.

Of the 250 cases, 19 were treated at the contagious disease hospital or were treated at home and the susceptible childhood contacts taken out. In this group there were 60 susceptible familial childhood contacts, but no secondary cases of scarlet fever occurred.

In the group of 250 cases, there were 550 adults exposed. From this group of contacts six secondary cases developed. In the large group of casual contacts, i.e., extra-familial contacts, no secondary cases occurred. (Table 1.)

SUMMARY

From this survey it is apparent that:

1. One out of every 6 or 7 susceptible childhood contacts within the home will contract scarlet fever during the quarantine period.

2. Secondary cases of scarlet fever may be prevented best by either removing the patient to the contagious disease hospital or removing the susceptible contacts from the patient.

3. Only a small number of adult familial contacts contract the disease, namely between 1 and 2 per cent.

4. The number of cases contracted by casual extra-familial contacts is so small as to be negligible.

808 North Spring Street.

Table 1.—*Contagiousness of Scarlet Fever in Relation to Environment*

	No. of Cases	No. of Familial Childhood Contacts	No. of Secondary Cases	Per Cent of Secondary Cases	No. of Adults Exposed	No. of Secondary Adult Cases
Treated at Home.................	231	383	60	15.6	500	6
Treated at Contagious Disease Hospital	19	60	0	0	50	0

EMERGENCY MATERNITY AND INFANT CARE (E.M.I.C.) PROGRAM*

W. Benbow Thompson, M. D.
Los Angeles

EVENTS affecting the administration of E.M.I.C. (Emergency Maternity Infant Care program of the Federal Children's Bureau) have occurred with such rapidity that it has been almost a full-time job to keep up with the procession. Changes in policy of major importance are now being proposed, and since these are suggested by the California Medical Association Committee on E.M.I.C., it is distinctly in order to review the facts that have dictated the actions of C.M.A. official representatives.

At the last meeting of the C.M.A. House of Delegates, a report was accepted calling for decentralization of the E.M.I.C. administration, for supplementing the inadequate subsidy provided, and for elimination of some of the objectionable features in the forms insisted upon by the Federal Children's Bureau. Resolutions were drawn up, setting forth the attitude of California physicians, which were presented to the A.M.A. House of Delegates. The important fact, however, is not that resolutions were presented at Chicago, but that in Los Angeles the southern members of the C.M.A. Maternity-Pediatric Committee approved basic modifications of the program, and, by implication, approved the program when and if these modifications became effective.

Following the above meeting, an opportunity arose of presenting directly to the Children's Bureau the objections of the medical profession of California. E.M.I.C. is no small affair. Approximately one birth in six, in this State, is under E.M.I.C. auspices. Only New York is caring for a larger case-load of service dependents. Hence objections and suggestions from this area should carry considerable influence, if one grants that the Children's Bureau is at all able to judge evidence.

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* Report on meetings held in Washington, D. C., on June 4-5, 1944. Report is submitted by request. For cross references on California and Western Medicine, see issues of May, 1944, on page 259, and June, on pages 295 and 305.

In current issue of C. and W. M., see also on page 114.

CHILDREN'S BUREAU CONFERS WITH OBSTETRICIANS

Preliminary Conference.—At the suggestion of N. J. Eastman of Johns Hopkins University, chairman of the Advisory Committee to the Federal Children's Bureau, the Bureau, on June 5th, held a conference with seven members of its Advisory Committee and twelve obstetricians drawn from various parts of the country. Probably because of my appearance on April 27th, 1944, as a representative of the California Medical Association, at the House Sub-Committee on Appropriations to the Labor Department, I was included in the list of those invited. Because this was the first attempt by the Bureau to discuss its program with those who actually provide service to the service men's wives, it seems worthwhile to recount some of the discussions presented.

Prior to the Bureau conference, we invitees met with the Advisory Committeemen at Johns Hopkins Hospital on Sunday, June 4th. Afternoon and evening sessions were taken up in wordy debates and discussions, mostly of little value except that they cleared away much preliminary chaff that would have been thrashed out before the Bureau. The result was that, at the Bureau meeting, there was not much useless conversation, so that the preliminary conference was distinctly beneficial.

Conference Proceedings.—Without stenographic notes, it is impossible, a month later, to report the discussion accurately. Only a broad, general picture can be given. Sometime, somewhere, an expurgated account will be given out by the Bureau, but unless I miss my guess completely, it will be as tame reading as was the report of the conference with Pediatricians held by the same Bureau.

Dr. Martha Eliot, author of "Design for Tomorrow's Maternity Care," presided, and opened the session by introducing Miss Katherine Lenroot, Chief of the Bureau. Miss Lenroot, and then Dr. Eliot, spoke feelingly of their affection for the newly-poor service wives. One gained the impression that their only interest was a selfless concern, and those of us who felt that the Bureau's program was chiefly an effort to maintain the Bureau personnel on the public payroll were supposed to be properly squelched. Again and again, these two referred to the "broad, general, principles" of their project, and expressed their regret that the various State Boards of Health, to whom actual field administration is delegated, had arranged rigid and inelastic restrictions in providing for the service dependents. Later, some of us referred to this phase of criticisms and pointed out that a State program meeting the specifications of the Bureau directives must of necessity be entirely lacking in elasticity.

If space permitted and notes were available, much that was said would bear repeating.

C. H. Danforth of Evanston gave very clearly the reasons why a master-list of consultants in obstetrics would increase resentment of other equally-qualified practitioners. (We found that out in Kern County, in California, as will be noted later.)

Brackett of Rhode Island discussed the impropriety of insisting that a service-wife be limited in her selection of an obstetrician to those men for whom $50.00 is at least a semiadequate recompense. In a most logical manner, he pointed out that patients in general go to the men whose services they can afford, and that the Bureau is actually, by making service wives an unattractive group in a financial sense, lowering the standards of care provided them.

S. A. Cosgrove, of the Margaret Hague of Jersey City, referred to the publicity of the Bureau which tends to educate the public to acceptance of $50.00 as a proper fee in obstetrics, whereas, in matter of fact, a proper fee will vary according to living and professional costs, individual professional ability, and a whole host of other factors.

E. D. Plass of Iowa City, himself a member of the Advisory Committee, warmly castigated the Bureau for its attempts to regiment the practice of obstetrics, and to regiment the patients who are dependent upon the Bureau for their medical care. All present—with two exceptions—entered into these or other discussion, but the men mentioned especially aroused my interest.

On the agenda for the Children's Bureau conference, there was the following item:

"3. How can hospital maternity clinics, especially in teaching centers, best be utilized in the program?"

Most of the obstetricians invited, and all of the Advisory Committee Members, are connected with teaching institutions. For some reason these professors could see no harm in filling their teaching requirements with the service dependents. Their usual sources of clinic material have fallen off, due to the increased income of the people who used to patronize free clinics. No one arose to point out that, if Dr. Eliot succeeds in establishing her "Design for Tomorrow's Maternity Care," which provides that all maternity attentions shall be paid for by the State, and if the Bureau maintains its attitude that $50.00 is adequate compensation for maternity attention, then there will be no need to educate specialists in the obstetrical field. Instead, the professors should divert their applicants to other phases of medical practice, except possibly neuro-psychiatry. The neuro-psychiatrists are going to be entirely too busy as it is, in treating colleagues who have gone nuts over filling out Government forms and trying to make ends meet, on $35.00 and $50.00 obstetrics.

MALPRACTICE INSURANCE LIABILITY INCREASED*

My own part was chiefly to present the opinions of Attorneys W. R. Rains and W. W. Vaughn, the attorneys for the Medical Protective Company, the Canadian Liability, and Lloyd's Insurance Companies, carriers of malpractice insurance in California, and of Dr. Louis J. Regan, chairman of the Medico-Legal Committee of the Los Angeles County Medical Society. It had occurred to me that the contract set forth on Form M. as dictated by the Children's Bureau. was a rather formidable legal document, and just before leaving for Washington, I had the happy inspiration to submit the form to these attorneys. Almost as if they had acted in concert, which I know they did not, they condemned the contract as increasing the liability of the individual physician who signs it. Moreover, they indicate that the insurance carriers will be forced to increase rates to cover the increased liability, and that, even then, a breach of contract action will not be one for which the usual policy provides coverage. I therefore informed the Bureau that, so far as California was concerned, there was to be prompt revision of the program, which would eliminate some of its objectionable features, including the contract, or else that E.M.I.C. in California would have to get along without the participation of many members of the medical profession. One of the attorneys for the Labor Department, who was present, said that he thought that the courts would not consider Form M seriously in malpractice or breach of contract actions. My reply was that we would be guided by the opinions of the Insurance Companies' legal advisors, who not only were thoroughly familiar with medico-legal affairs, but who had at heart the interests of the medical profession.

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* For opinions, see in this issue, on page 114.

Within a few days, Drs. Halverson, Bierman, and Hayes, of the State Board of Public Health, met with Drs. Schaupp, Kress, and Wolfson of the California Medical Association Committee, to consider the revised application form that had been drafted by the Bureau of Maternal and Child Health of the California State Board of Public Health.

The proposed changes and revisions were discussed and it was agreed that certain suggestions should be submitted to the Federal Children's Bureau. This action was later approved by the Executive Committee of the California Medical Association, and on July 21st, the suggestions were presented in person by Dr. Jessie Bierman, at the conference held in Washington, D. C.

CHANGES IN ADMINISTRATION

The major changes in administration provide for State autonomy of supervision. Our own State Board of Public Health knows the situations that confront us, and should not be restricted by regulations designed, for example, for Florida. At the Bureau conference of June 5th, each of us mentioned problems purely local in character, and many of us spoke of the impossibility of establishing nation-wide rules applicable with fairness in all parts of the Country. Our State Boards of Public Health are perfectly capable of dealing with us and our difficulties. We insist that they be allowed to do so without interference from Washington.

"Form M," the "contract" so carefully designed by the Bureau, in the modified form submitted by us, *authorizes* the State Board of Health to pay directly to the named physician and hospital, the amount provided by subsidy. Thus the objections of the profession relative to direct grants are met in full. Further, the patient can indicate her desire and ability to supplement the amount of the subsidy. No longer will the subterfuge be encouraged of holding Form M until a sufficient amount of preauthorized service has been given to permit the collection of a fee in keeping with the standards of this area. On the doctor's side, he states that he will furnish to the dependent the service he provides for other patients, and that his total charges will be a stated amount. Reference to this last item will be made later.

CONSULTANTS

In accordance with Federal Bureau desires, an attempt was made some time ago to provide a list of consultants for various areas in California. This was relatively easy in the larger centers, where adequate numbers of holders of Certificates from the American Boards of Obstetrics and Pediatrics are to be found. In the more sparsely-settled areas, however, this proved a headache. In Kern County, several men were selected by the California State Health Board's Bureau of Maternity and Child Welfare, on the advice of an Advisory Committee. The men named did not ask to be designated as consultants, and did not have prior knowledge of their appointment. The doctors of Kern County seethed with indignation. They passed resolutions condemning such bureaucratic shennanigans—and they were right. Even before the resolutions were received, the inadvisability of selecting certain men as consultants was recognized. Kern and other counties have been advised that, in any emergency, a doctor may and should call as a consultant the man that he would prefer, and the State Board of Health will recognize that man as the proper consultant.

FEE SCHEDULES

Not much has been done with the fee schedule. It should be evident that, although fees in California are properly higher than, for example, in the Ozarks, it is impossible to devise a fair adjustment for one State as against other States. Dependents' allotments are standard for all, and the medical allotment, if it can so be designated, must be uniform throughout the United States. However, two changes are made to provide somewhat for the unusual patient. Under previous rulings, any and all complications were at the attending physician's risk. Hereafter unusual complications and care will be remunerated at an increased amount. As an example, the doctor whose patient develops pneumonia during or after pregnancy will, upon presentation of data supporting his diagnosis and the extra attention involved, be given a fee above the base rate. Not enough, probably, but at least enough to indicate that our State recognizes his increased responsibility. The doctor whose patient needed a Cesarean formerly could call in a consultant to operate who was paid $50.00, or do it himself if he felt able to do so, but in the latter instance it was one of the operations he had contracted to furnish and he received no addition to the fee coming to him as if it had been a normal case. Under the modification suggested (if approved by the Federal Children's Bureau) he would receive $100.00, provided he calls in a consultant who agrees that the operation is necessary.

Some rules and regulations still are necessary. We believe that the fewer and more general these are, the more responsibility and coöperation can be expected from the medical profession. Thus far, the Federal Children's Bureau's attitude of distrust of the medical profession and its attempts to regulate every possible phase of professional conduct have not restrained in any particular the members of the profession whose conduct has bordered upon the unethical, but on the contrary has served to bar many doctors who resent the implications that all doctors are crooks and shysters. Undoubtedly a certain amount of chiseling will still be carried on. It is suggested that each County Society appoint or elect a small grievance committee to consider complaints from both patients and doctors in their areas. Such local committees would be urged to discuss their local problems with the State Board of Health and with the C.M.A. Committee on E.M.I.C., in a sincere effort to handle the professional problems with professional understanding.

The modified plans of the C.M.A. Committee contemplated providing four main plans of handling service applicants.

The largest group at present are women accustomed to city maternity and county hospital attentions, and who are delighted to find that these facilities are available to them regardless of residency.

It is the woman accustomed to private care, and unwilling to be classed as an indigent or pauper regardless of her newly-decreased financial status, who presents the more difficult problem that confronts us. For her, too, services should be developed. She may go to those men willing to accept service dependents for the amount of the Federal subsidy or, in the larger centers, she may go to semiprivate clinics developed in the individual hospitals. In one California city, we have one hospital now arranging to care for some fifteen cases each month. Applicants will be assigned in rotation to the obstetrical staff members, and will receive private prenatal care exactly as other private prenatal patients. At the onset of labor, the patient will not call the doctor who has been attending her, but will go directly to the hospital where her delivery will be supervised and attended by one of the obstetrical staff members. The probabilities are that it will not be the individual with whom she has become acquainted, but she will receive specialized prenatal attention and specialized delivery care at no cost to her. It is hoped the other major hospitals in this area to develop similar methods of providing for these patients.

It must be borne in mind that any patient, desiring other than county hospital or indigent clinic care who is diverted to such indigent service, becomes a vote for government socialized medicine. Each of us must feel the responsibility of doing everything possible to decrease the demand for Federal intervention in the practice of medicine, and hence each of us has a duty to his fellow-physician to care for as many service dependents as is physically possible.

The fourth group are those able to supplement the Federal grant and hence able to select their obstetrician with entire freedom. It is probable that the amount of the supplementary payment so offered will not approach the usual fees of a given obstetrician, and the specialist is as much under compulsion to give his usual services at reduced fees as are the general practitioners who are now carrying the chief burden of this new class of patients. Specialists also should feel the necessity of consulting with their fellow practitioners at the low fee stipulated from the Federal funds.

The above has been written hurriedly to meet a deadline. There is no opportunity for polishing. Probably this is an advantage, since there can be no attempt to placate individuals or groups. When it comes to reporting the activities of the Children's Bureau, my tendency is to wave my arms and become violent. The only concession I have been able to make in this has been to delete some of my choicest invectives and best Peglerese. It is indeed difficult to maintain coherence when discussing details with bureaucrats.

No one can say the modified program, as suggested, is perfect. That is entirely too much to ask. It should, however, be more satisfactory than the regimentation demanded by the Federal Children's Bureau. At least it is a program in which the doctors of California would have a voice and a direct interest.

What action the Bureau's authorities at Washington will take, is not known at this writing. Comment thereon must be postponed for future presentation.

1105 Equitable Building, Hollywood and Vine.

* * *

Note. At the conference held in Washington, D. C., on July 20-21, which was called to consider some of the problems that had arisen in the E.M.I.C. program, the suggestions that had been formulated by the California Medical Association Committee on Maternity-Pediatric Work, were submitted.

Dr. Martha Elliott stated that any supplemental fees to be paid by patients who had means and who were willing so to do (such fees in addition to the $50.00 established in the E.M.I.C. Program), could not be considered at the present time.

The representatives of E.M.I.C. promised to consider the other suggestions presented by the California Committee, but at the date on which this article appears in California and Western Medicine, no letter on the subject has been received from the Federal Children's Bureau.—Editor.

KENNY TREATMENT IN POLIOMYELITIS: AN EVALUATION*

J. Wayne McFarland, M. D.
Los Angeles

THIS evaluation of the Kenny treatment is based on a study of 280 cases of poliomyelitis which occurred during the years 1942 and 1943. We are well aware that this report cannot be a final estimate of what the Kenny treatment has or has not done, because not a sufficient period of time has elapsed. However, we believe there is enough evidence from the progress made thus far to give us a fair basis from which to draw our conclusions.

With few exceptions, these cases were treated at the Los Angeles County Hospital during the acute stage of the disease, and were followed at other hospitals or as outpatients in one of the several clinics set up for follow-up care. This is not the total number of cases that entered the Contagious Disease Building of the Los Angeles County Hospital during 1942 and 1943, but represents 50 cases from the year 1942, and 230 cases from the year 1943, which we have been able to follow consistently.

Of this group there were 199 patients under 14 years of age, and 81 who were 14 or over, the average age being 11 years. The youngest was 4 months and the oldest, 43 years. The average stay in the hospital for the total group was 45 days. In the year 1942 there were 8 bulbar cases and 2 respirator; and in 1943 there were 8 bulbar and 3 respirator cases.

We found spasm to be present in one hundred per cent of the cases studied, which is in accordance with the findings of the Minneapolis group.[1] The spasm occurs most frequently in the neck, back, and hamstrings. It has become almost a dictum with us that if spasm is not present, one should be suspicious that the case is not that of infantile paralysis. In other words, spasm alone may occur without paralysis, or spasm may occur along with paralysis, but paralysis without spasm we have yet to see.

We can also state unequivocally that this spasm of the muscles, with its associated pain and tenderness, was markedly relieved by the application of Kenny packs. And we agree with Steindler, et al,[2] that the majority of cases are relieved of their acute pain and tenderness within 48 to 72 hours.

CLASSIFICATION OF CASES

In the evaluation of our end results, in the present study, we have placed more emphasis on the useful function of a limb to a patient than upon the muscle grade of that limb; for we have discovered that functional results under the Kenny system of treatment are dependent more upon early packing of muscle spasm, followed by proper muscle reëducation, than upon the degree of power that is present.

Table 1 gives a comparative study of the 280 cases in this series, divided as to their original involvement and showing the final disposition of the cases as to their function.

The five groups, according to the degree of original involvement, are as follows:

1. Extremely severe—extremities with complete paralysis, and severe bulbar and respirator cases.
2. Severe—Extremities in which the muscles were graded poor, traces, or zeros.
3. Moderately severe—Extremities in which the muscles were graded fair or poor.
4. Slight—Extremities in which the muscles were fair and above, with only slight weakness.
5. Normal—Extremities in which there was no weakness, or abortive or preparalytic poliomyelitis.

The amount of functional recovery is based on the following classification:

1. Normal—No paralysis, no residual weakness, or so slight as to be inconsequential. (All muscles good or normal.)
2. Excellent—No braces, crutches, or sticks. Muscle weakness present, but does not limit usefulness of extremity.
3. Good—No braces, but the patient uses crutches or sticks. The muscle weakness present does not require bracing.
4. Fair—Braces or other type of support required. Function is limited by contractures, or there is only a partial return of function of an extremity that was severely involved at the onset.
5. Zero or Poor—Function is nil. There has been slight or no return of power.

Table 1.—*Functional Results of 280 Cases of Poliomyelitis Treated by the Kenny Method*

This table gives a comparative study of the 280 cases divided as to their original involvement and final function, as explained in the text.

Degree of Original Involvement	No. Cases	Zero or Poor		Fair		Good		Excellent		Normal	
		No.	%	No.	%	No.	%	No.	%	No.	%
Extremely Severe	38	8	21	11	29	10	26	7	19	2	5
Severe	60			2	3	11	18	19	33	28	46
Moderately Severe	24					2	9	8	33	14	58
Slight	31							3	10	28	90
Normal	127							2	2	125	98
TOTAL	280	8	3	13	5	23	8	39	14	197	70

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* Read before the Section on Public Health, at the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

From the Department of Therapeutics, College of Medical Evangelists and the Contagious Disease Section of the Los Angeles County Hospital.

Acknowledgment is made for the technical assistance of the physical therapy technicians in the above-named institutions.

RESULTS AS TO FINAL FUNCTION

It will be noted on the Table that, of the 38 cases which were extremely severe in their original involvement, 50 per cent ended with good and above in their functional results. Of the 60 cases that were severe at the onset of the disease,—which means that all of them had extremities in which there were poor or trace muscles,—46 per cent had complete recovery, and 33 per cent, although showing muscle weakness, did not require crutches or sticks in their walking. There were 24 moderately severe cases, all of which had good or better end-results. There was 90 per cent normal recovery in the 31 cases that showed only slight weakness at the onset. Of the 127 abortive, or preparalytic cases, where only muscle spasm was present, only 2 per cent later showed definite muscle weakness.

Taking the cases as a whole, it is very interesting to note that 84 per cent had excellent or normal functional recovery. Only 5 per cent of the cases ended with fair, and 3 per cent with zero or poor function. The last two groups are those which required braces, or their function was impaired due to the lack of return of sufficient muscles to make a useful extremity, or due to tightness which limited function. Actually there were only 8 of the 280 cases on which braces were used, and 2 of these patients have had the braces removed.

This leaves 23 patients, or 8 per cent, who have brace-free extremities, but must have crutches or "Canadian sticks" in order to walk. A portion of these may eventually require some type of support which will place them in the "fair" functional group. However, we feel a good percentage will remain as good functional recoveries, with some of them finally being able to carry on normal activity without the use of their crutches or sticks in spite of residual weakness.

SPASM AND SCOLIOSIS

Because Sister Kenny feels that spasm undetected or inadequately treated is the most damaging symptom of infantile paralysis, and that it is the cause of impaired function more than paralyzed muscles, the relationship of muscle spasm to scoliosis is very enlightening.

There are 41 out of the 280 cases who now have some degree of scoliosis. Nineteen, or 46 per cent of these 41 patients have had adequate care, and the spinal curvature is either stationary or improving. Twenty-two cases, or 54 per cent of the 41 have not had adequate care. This group had Kenny treatment during the contagious period, but packing or muscle reëducation was either discontinued or not followed long enough. This becomes more significant by noting that only 5 out of the 22 inadequately-treated cases had any muscles paralyzed at the onset. The remaining 17, or 80 per cent, were preparalytic or abortive poliomyelitis, and yet they developed scoliosis. All of the cases had spasm of the back muscles at the onset. This would seem to indicate that back spasm which is not adequately treated is a potential cause of scoliosis, and it follows that adequate packing and muscle reëducation cannot be overemphasized in the prevention of curvature of the spine.

SUMMARY

A study of the Kenny treatment in 280 cases of poliomyelitis occurring during the years 1942 and 1943 has been analyzed as to functional results as follows:

1. Eighty-four per cent ended with excellent or normal function requiring no support of any type.
2. Eight per cent ended with good function, that is, they required no braces, but used crutches or canes.
3. Five per cent ended with fair function, and three per cent with zero or poor function. These two groups required supports or braces, or function was impaired beyond hope of recovery.
4. Muscle spasm is more often the cause of poor function than is muscle paralysis.
5. Inadequate treatment of abortive poliomyelitis may often result in scoliosis.

CONCLUSION

We have had our sense of values changed since the advent of the Kenny method. More emphasis is placed on spasm, its detection and treatment than upon caring for paralyzed muscles. This is rightly so, for we have many patients with weakened or completely paralyzed muscles, yet because there is no tightness or contracture they have excellent function.

The Kenny method of treating poliomyelitis has given us consistently good functional results. It is our opinion that with this method of treatment the development of contractures, and the need for bracing and other support is greatly reduced.

Boyle and Michigan.

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("Free Enterprise." Concluded from Page 121)

and our school districts. We must assume responsibility for direction of local affairs. We must analyze the proper function of local governments and we must make them more efficient and more responsive to the needs of the people. Above all we must quit running to Washington for help, because it becomes increasingly clear that if we continue to turn to the vast governmental machine in Washington for solution of problems which we ourselves should solve, all local responsibility and self-direction will ultimately be destroyed.

All organizations, business, civic and scientific, must ally themselves in the battle; they must join in a campaign of education which will inform the individual citizen of the dangers inherent in continued Federal encroachment.

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* * *

FOREWORD: AN EXPRESSION OF APPRECIATION

The California Tuberculosis Associations are deeply appreciative of the courtesy extended by the California Medical Association in making it possible to present the papers read before the 1944 annual meeting of the California Tuberculosis and Health Association and the California Trudeau Society. It is hoped that this presentation will be of interest to general practitioners.

The California Tuberculosis Associations are anxious to continue the close and pleasant association which they have always had with the medical profession of the State, to the end that all our communities may approach the ideal level of community health.

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ORIGINAL ARTICLES

TUBERCULOSIS SUPPLEMENT

Scientific and General

TUBERCULOSIS ASSOCIATIONS OF TOMORROW*

William P. Shepard, M.D.
San Francisco

THIS annual meeting of the California Tuberculosis Association is a momentous occasion. For the first time we have become a million-dollar enterprise. Never before has the public been so generous in its purchase of Christmas Seals. Never before has it been so apparent that the people want tuberculosis controlled. Never before have our control methods been more effective. We have come through the second war year without a general increase in the tuberculosis death rate. We have received a strong vote of confidence. Our responsibility to respond effectively was never greater.

Since we are a federation of county Associations, this responsiblity rests equally on many people. It must be borne by the boards of directors and staff members of each of our associations. A major concern of the board of directors of the State Association is to see that each county association gives full value received to its supporters. How may we best do that, and having done it, what does our future hold?

Our original purpose and first responsiblity is to control tuberculosis. Within the limitations of the funds available and the demands of the local situation, it is incumbent on each association to make available to its citizens all of the tuberculosis control measures which we know are effective.

These include:

1. *A full-time health department well supported by public opinion.* Without the legal authority vested in the health officer it is often impossible to isolate promptly known cases of infectious tuberculosis. Legally, no one else can do this but the health officer.

Organizing public opinion is a task of health education. It belongs to the voluntary health association. Lack of a well-supported health department presents an immediate job for the tuberculosis association.

2. *Provision for adequate hospital beds for the isolation and treatment of tuberculosis cases.* Every community should have access to at least two beds per annual death. It is a matter of great pride to this Association that 90 per cent of the population of the State has access to tax-supported sanatorium beds, and that the quality of treatment rendered in these sanatoria is supervised through the State Department of Health which controls the State subsidy.

3. *Support and coöperation of physicians.* No one in any community is more impressed by the tragedy of tuberculosis than the practicing physician. No one is more aware of its preventability. His fullest support and coöperation is a foregone conclusion, provided he understands the program.

Once they understand the problem, physicians generally agree that tuberculosis control among the masses cannot depend solely on people calling their private physician when they suspect that they are afflicted. The onset of the disease is too insidious and the mental attitude of the average patient too resistant. By the time the patient usually sees his physician, he is already weakened by toxemia and weight loss, and has probably been spreading the disease for months. He is already in the moderately-advanced or far-advanced stages, and the prognosis is correspondingly darkened. Physicians commonly agree that some mass approach to the problem of finding the symptomless case is essential.

4. *A modern case-finding program.* Once medical support is assured and facilities are provided for the isolation and treatment of tuberculosis, there is no limit to the thoroughness with which case-finding can be pursued. The ultimate in case-finding is probably a chest x-ray and medical examination for every person each year. Impossible as this may seem, some industries are approaching it. The town of Eveleth, Minnesota, last year succeeded in x-raying every man, woman and child living there!

5. *A well-conceived, skillfully-conducted program of health education.* Much of the case-finding program is educational, and none of the many educational opportunities it presents should be neglected.

Health education hinges upon sound medical information. We must rely solely on our medical friends to tell us what health truths to teach, what they recommend that people *think* and *do* to improve their health and avoid tuberculosis, which new discoveries are worth teaching and which are not, which old procedures are outmoded and should be dropped from our teaching.

Physicians and scientists furnish us the raw material of health facts. We then manufacture the devices needed to put them into general practice by the public.

What of tomorrow? We must recognize the fact that, for many years, the tuberculosis death rate has steadily declined and the Seal Sale income increased.

Suppose for the sake of argument, although it seems unlikely now, that a specific cure for tuberculosis is discovered tomorrow. What a boon to mankind! What a blow, welcome as it would be, to the tuberculosis associations! Regardless of such wild speculation, the day will come when Seal Sale receipts will exceed the amount we can use wisely and practically for the control of the small remaining amount of tuberculosis. When that day comes what shall we do?

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* Address of the President. Read before the California Trudeau Society, and the California Tuberculosis and Health Association, Los Angeles, March 29, 1944.

Three choices are immediately apparent. One is to close up, tell the public "our job is done, thank you and goodbye." Another is to limit the amount we will accept, reducing that limit as tuberculosis declines. A third is to direct our activities to some other health field. Obviously we cannot change our program overnight. We would probably not have occasion to do so, since there is every likelihood that tuberculosis will be with us for many years to come. But as tuberculosis continues to decline we might begin to broaden our base of operations to feel our way slowly and experimentally into other health fields. Let us examine this possibility.

Actually, our work has never been solely confined to tuberculosis control. We have always been a general public health agency, primarily concerned with tuberculosis. At the very beginnings of the antituberculosis movement it became apparent that improved general health was our ultimate aim. We have worked to provide hospitals, sanatoria, and health departments. We have been responsible for legislation designed to improve the public health. We have taught the values of good health habits, proper nutrition, rest and exercise. Our educational program in schools has been largely a general health program, not solely a tuberculosis program. In heavily-infected communities, and in groups of the colored race especially, we have learned that we cannot limit our attention to tuberculosis and remain indifferent to other lung diseases, or to such things as heart disease, syphilis, malnutrition, cancer, diabetes, industrial hygiene, and mental hygiene.

As a matter of fact, we have developed an organization which is much more valuable in the field of general health than many of us realize. It is an organization in which specially-trained health workers build a life-time career. It is a potent influence in the community. It is well and favorably known by the public. It guides and molds public opinion effectively and this is done largely by educational methods, rather than by propaganda and the techniques of pressure groups. We share, as fully as any other organization in the country, credit for the nation's general health improvement over the past 50 years.

This organized public health movement, effective as it is, reaching into every corner of the land as no voluntary health agency has done before, seems too precious a machinery to abandon. Its usefulness will continue for many years to come. It will continue as long as mankind is afflicted with illness and death which are preventable, and the prevention of which depends on the individual's knowing and doing something about it.

To broaden our base of operations at the State level seems a wise step at this time. Precisely how and when it is to be done by county associations which have not already done so, depends on their own judgment of local conditions and needs. To aid county associations in this important step, a special committee has been set up by your State Board of Directors to discuss with local associations this and other questions of meeting our responsibilities to the public. This committee's recommendations will be considered when renewing the annual Seal Sale contracts.

As with most progressive steps certain dangers must be recognized. Two precautions are to be constantly kept in mind. If disregarded, even momentarily, they can cause great harm.

The first is to remember that tuberculosis control is our first responsibility. In this field we are well schooled, and we have a varied armamentarium. Tuberculosis will probably be with us for many years to come. We must keep our eyes on this adversary and never lose sight of it. It is our age-old enemy, more constant, more dangerous and, in the long run, more destructive to human life than all the wars of the present and past.

It would seem that we are now powerful enough to carry this crusade to ultimate victory with our good right arm, while we begin to engage other enemies of mankind with the other. Some of these enemies are more formidable than tuberculosis. They are capable of catching us off balance so that tuberculosis may slip up on us again. To be forewarned is to be forearmed. Our strategy in any event is never to let up on our first enemy, now in retreat.

The second precaution is to recognize and preserve a unique and precious ingredient of the antituberculosis movement. It has existed so long we might overlook it. This is the happy and effective relationship between medical leaders and community leaders. Tuberculosis control as community activity has had the best of medical guidance. Both our national and our state associations were conceived in the minds of physicians and founded by them. Without their sound advice, much effort and money might have been wasted. Without medical skill and judgment in guiding the movement, much valuable research would have been neglected or misinterpreted. Whatever the future may hold for this organization, the best medical thought and guidance must be continuously available. It must be as readily sought and as quickly accepted by our nonmedical members as it has been in the past. This is just as essential in the control of heart disease, cancer, and venereal disease, and to industrial hygiene and mental hygiene as it has been in controlling tuberculosis. Programs in these fields may require expert medical advice from slightly different sources. But we must never be without medical guidance.

600 Stockton Street.

There can be no divided allegiance here. Any man who says he is an American but something else also isn't an American at all. We have room but for one flag—the American Flag.—Theodore Roosevelt.

RARE TUBERCLE BACILLI IN SPUTUM: THEIR SIGNIFICANCE*

F. M. Pottenger, M.D.
and
J. E. Pottenger, M.D.
Monrovia

In a previous paper the authors discussed the difficulty of rendering sputum negative when once positive for tubercle bacilli. We showed in detail the after-history of a group of patients who were followed for as many as fifteen years and reëxamined at intervals after treatment had ceased, and stated that it was our opinion that "completely and permanently negative sputum is rarely attained in those who have suffered from destructive and especially widespread pulmonary tuberculosis, even though they are clinically well and able to do their usual work."

Some workers have misunderstood our statement, thinking that we are of the opinion that tuberculous patients, when once showing bacilli in the sputum, rarely become free. On the contrary, of the eleven cases reported in our study, two, who were suffering from a recent exudative invasion (one with, the other without cavity) were both bacillus-free on all subsequent sputum examinations; and a third, who had an acute bilateral infiltration with cavitation in both lungs, became free, and rare bacilli were found on two occasions only, two and four years after the end of treatment.

DIFFICULTY IN RENDERING SPUTUM NEGATIVE

Our opinion of the difficulty in rendering sputum negative is based on our own experience with a refined technique, by which bacilli may be found when an entire specimen examined, even though it be saved for seventy-two hours, may not contain more than a few hundred bacilli. This technique gives 20 to 250 times (average 80 times) as many bacilli in a unit time of search as the Ziehl-Neelsen method. The average is made from over 400 comparisons. The technique is relatively more efficient in the examination of purulent specimens than in those muco-epithelial in character.

Our patients consist of all cases who have come under our care in the past twenty years, both in the sanatorium and in the clinic; and inasmuch as we give our services to all who desire them, the prognosis of many of our patients is unfavorable when first seen. Some even are beyond the possibility of improvement, let alone healing. We also have a large group with minimal lesions, or who have previously recovered from limited lesions, most of whom are negative at the time of examination. Many of these are clinic cases.

SPECIMENS FROM 3,794 PATIENTS

At this time we are discussing 3,794 patients on whom 27,405 examinations were made. Of this number 2,847 (75.1 per cent) were always positive, and 947 (24.9 per cent) were intermittently positive and negative.

Our advanced cases were usually suffering from extensive disease, and bilaterally involved. Our patients were treated by all of the usual methods, physiological and surgical, always giving the physiological methods a chance before using compression. It is our experience that those cases which produce the best results under compression are the ones which do the best without it. Furthermore, by waiting we find that many which seemed to call for pneumothorax are able to heal spontaneously. In our experience, we have found that patients whom we consider suitable for hygienic treatment, pneumothorax or thoracoplasty, all respond to treatment with rare and negative sputum to about the same degree. Only thirty per cent of our patients give negative guinea-pig tests, with a 15-day inoculum, after showing three successive negative tests by dilution-flotation. Some of these who still show rare bacilli when they leave the institution will become negative with the passing of time, as we have found by our follow-up examinations.

Of 947 patients who were intermittently positive and negative, bacilli were found on 5,837 examinations, and were absent 4,436 times. Of 365 patients in whom tubercle bacilli were reported positive by dilution-flotation, all would probably have been negative by Ziehl-Neelsen. Some 243 of these were confirmed by guinea-pig; 30 more were examined once only, but had carried bacilli in abundance on previous occasions; and 92 patients of the group were examined but once, without confirmation by guinea-pig test.

North Canon Boulevard.

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* From the Pottenger Sanatorium and Clinic, Monrovia, California.
Synopsis of a paper read before the California Trudeau Society, Los Angeles, March 29, 1944.

DISAPPEARANCE OF TUBERCLE BACILLI FROM PULMONARY EXCRETIONS FOLLOWING TREATMENT*

C. Richard Smith, M.D.
Los Angeles

We are well aware of the chronicity of tuberculosis and its tendency to relapse. We could readily find plenty of cases to demonstrate the persistence of positive sputum following treatment, but the object here is to show the optimistic side.

SPUTUM EXAMINATION PROGRAM

Our sputum examination program includes at least one test in each calendar month. The procedures employed are direct smear, flotation-concentration, culture, animal inoculation, and stomach contents examinations. In our flotation-concentration test, the smears are examined each period of 10 minutes. For culture, the sputum is dissolved in ½ per cent sodium hydroxide, treated with oxalic acid 2½ per cent, centrifuged, and the sediment planted on two tubes of Petragnani's medium. For animal tests the sputum is shaken with ½ per cent sodium hydroxide, centrifuged, the sediment washed and then inoculated subcutaneously into a guinea pig. The animals are allowed to go two months before autopsy if clinically negative. Visceral disease is required as evidence of tuberculosis. Stomach contents are examined only by culture and animal inoculation.

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* From the Barlow Sanatorium, Los Angeles.
Read before the California Trudeau Society, Los Angeles, March 29, 1944.

All direct smears are on 24-hour specimens. Concentrations, cultures and animal inoculations were on three-day specimens up to February, 1939, and thereafter on six-day specimens unless the patient expectorated unusual quantities of sputum. The six-day specimens are collected two days at a time and ice-boxed until the whole amount can be pooled and examined. Concentration has always been accompanied by culture done simultaneously on the same specimen. Culture is now frequently done alone, but concentration never without culture. During the past four and one-half years culture and inoculation of a six-day sputum specimen have been carried out at the same time as culture and inoculation of the stomach contents.

As a rule, the simplest test that will demonstrate the bacilli is used. When the patient becomes negative to one procedure the next more sensitive test is used. When negative to concentration and culture, or to culture alone, for three months, gastric lavage is performed with culture and inoculation of both sputum and stomach contents. In patients remaining negative, gastrics are performed about every 4th month.

THIRTY-DAY SPUTUM TESTS

A number of years ago the question arose as to whether we were really getting our patients negative. It was suggested that, if we inoculated all the sputum expectorated for one month into a guinea pig, most of our presumed "negative" patients would be shown to be "positive." Therefore, in June, 1938, we began performing 30-day sputum inoculations on those patients negative to all tests for six or more months. This means they will have been negative to at least one gastric examination. The sputum is collected two days at a time and ice-boxed. When a six-day batch has been accumulated, it is treated and inoculated. Inoculations are made in the right and left inguinal region and, if necessary, in the right and left axillary regions. Sometimes only one guinea pig was used, sometimes four, but usually two. Beginning in June, 1939, simultaneous concentration and culture were performed along with animal inoculation, but the specimens were not divided until they had been thoroughly dissolved and broken up by shaking with sodium hydroxide.

From June, 1938 to January, 1944, one or more 30-day tests have been performed on each of 86 patients. Of these 72 or 83.7 per cent were negative to animal inoculation as well as to concentration and culture.

Of the 14 patients that were positive ten were positive by animal alone, two by culture and animal, one by culture alone and one by concentration alone.

BACILLARY RECORDS OF PATIENTS DISCHARGED IN THE PAST SIX YEARS

A group of 284 patients who were resident in the Sanatorium six months or more, and who were positive at some time during their stay were studied. The disease rating is minimal in 18.3 per cent, moderately advanced in 50.5 per cent and far advanced in 31.2 per cent. Straight bed rest was the only treatment in 66 or 23.3 per cent, while lung collapse of one variety or another was applied in 218 or 76.7 per cent. The collapse therapy group is divided as follows pneumothorax alone or combined in 60 per cent, thoracoplasty as the principal treatment in 3.9 per cent, phrenic paralysis alone in 11.5 per cent, and other procedures in 1.3 per cent.

First, the group of 284 discharges was classified according to the number of months their sputum and gastric tests were negative prior to discharge and it was found that 46.1 per cent of all the patients in this group had "negative" tests four or more months prior to discharge, including at least one stomach contents examination. Twenty-eight per cent of them were negative eight months or more, including at least two "gastrics" and a 30-day sputum test in most cases.

TOTAL DAYS OF SPUTUM NEGATIVE PRIOR TO DISCHARGE

Next, it is of interest to record the total number of days of total sputum output examined and found negative by culture, concentration and culture, or inoculation prior to discharge, the intervening "gastrics" being negative, and this showed 116 patients or 40.8 per cent had 19 or more days of negative sputum and 91 patients, or 32 per cent, had 31 or more days of negative sputum prior to discharge.

FOLLOW-UP EXAMINATIONS

For several years we have attempted (when the technical help was available) to carry out a systematic follow-up examination schedule on expatients.

Recently, we have tried to perform gastric lavage, plus culture and inoculation, of a three-day sputum specimen in all cases except those known to be strongly positive, and here only sputum examinations have been done. The data below is for culture, flotation and culture or better.

One or more tests were performed on each of 236 expatients.

The examinations cover postsanatorium periods of from 3 months to 6 years, as follows:

3 months, 6 months and 1 year, in 78 cases;
2 to 3 years, inclusive, in 103 cases;
4 to 6 years, inclusive, in 55 cases.

The number of individual tests for each patient varied from 1 to 19, as follows:

1 to 2 tests, inclusive, in 101 cases;
3 to 4 tests, inclusive, in 88 cases;
5 to 6 tests, inclusive, in 30 cases; and
7 to 19 tests, inclusive, in 17 cases.

In 146 cases, or 61.9 per cent, all the tests were negative. In each of 90 cases, at least one test was "positive."

FOLLOW-UP RESULTS ACCORDING TO DISCHARGE RESULTS

It is of considerable importance to know the prognostic significance of negative sputum and stomach contents persistently and continuously present as a result of treatment. We do not feel that our follow-up examinations have been carried out for a long enough time by the more sensitive methods to adequately evaluate this point. However, the material at hand is suggestive. Below, follow-up results are classified according to the number of months the patient was negative prior to discharge:

0 to 1 month, follow-up tests negative in 41.3 per cent;
2 to 3 months, follow-up tests negative in 56.3 per cent;
4 to 7 months, follow-up tests negative in 76.1 per cent;
8 to 11 months, follow-up tests negative in 78.4 per cent; and
12 months or more, follow-up tests negative in 83.9 per cent.

These data indicate that the longer a patient is completely negative as the result of treatment, the more likely he is to remain "negative" in later years.

REPORT OF CASE

A young woman with moderately-advanced tuberculosis was given artificial pneumothorax which was improved by intrapleural pneumonolysis. Because of unusual circumstances, she was resident in the Sanatorium throughout her treatment. She became abacillary after nine months, and remained so for 54 months before and for one year after discharge. This represents a total of 272 days of "negative" sputum. It includes 28 concentrations and cultures, 21 cultures alone, two 30-day tests (one by guinea pig alone and one by concentration, culture and guinea pig), 13 gastric examinations by culture and guinea pig inoculation, and nine sputum inoculations with the gastrics and one alone. There were 17 negative tests after the lung had expanded, including six gastrics and six sputum inoculations covering a period of two years. (Editor's Note: Other case histories have been omitted to conserve space.)

COMMENT

In spite of persistent examination, including the most sensitive tests available, the tubercle bacilli disappear from the pulmonary excretions of almost half our patients following treatment. The sputum and stomach contents remain abacillary during at least 4 months of residence and, in the great majority, throughout the follow-up period of from three months to six years. Forty per cent of those whose sputum is not converted while resident in the sanatorium become "negative" later on. Nearly one-third of pneumothorax cases studied had had lungs expanded.

The absence of tubercle bacilli from the pulmonary excretions does not necessarily mean there is no active disease in the lungs. The lesion may be healed or it may be just closed off. The closed lesion, of course, may open again, and this happens fairly often.

On the other hand, the continued output of virulent microörganisms is a constant danger to the patient, to his family and associates, and to the general public.

It is true this situation is, in many cases, consistent with health and long life. But probably, in many more instances, the disease reactivates and spreads to other parts of the lungs, requiring further institutional treatment or resulting in death.

Even more important is the public health hazard of the bacillus-distributing person. Perhaps the ultimate solution of the tuberculosis problem will require elimination of such sources of infection.

Although the permanent disappearance of tubercle bacilli from the pulmonary excretions of all cases is our ideal, it has not been attainable. We are faced with the necessity of discharging still "positive" patients, although the majority are expectorating relatively few bacilli, detectable only by the more sensitive tests. The best we can do for these people is to teach them a way of life consistent with health, and to teach and impress upon them a few simple rules of hygiene which, if followed, will largely prevent infection in others.

SUMMARY

1. Patients negative for six months or more to an intensive sputum examination program were tested by animal inoculation of all the sputum expectorated for one month. These tests were completely negative in 83.7 per cent.

2. Of the patients discharged from the Sanatorium between 1937 and 1943, 284 were here six months or more. Of these 46.1 per cent became negative as the result of treatment, and remained so four or more months prior to discharge, and 28.0 per cent eight or more months.

3. In the same group 40.8 per cent had 19 or more days of negative sputum; 32.0 per cent, 31 or more days.

4. Follow-up examinations were performed in 236 out of 284 cases. From one to 19 or more tests were done over a period of three months to six years. In 61.9 per cent all of the tests were negative.

5. The percentage of negative follow-up tests is directly proportional to the number of negative months prior to discharge, varying from 41.3 per cent in those not converted, to 83.9 per cent in those negative 12 months or more before leaving the Sanatorium.

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REPORTS ON MEDICAL RESEARCH IN CALIFORNIA*

K. F. Meyer, M.D.
San Francisco

THE well-presented papers by Drs. Benjamin L. Freedlander and Sidney Raffel need no further comment. However, as a member of the Medical Research Committee of the California Tuberculosis Association, it is only proper to express our gratitude to the Association for the liberal support it has given these projects. When the plans for a joint financing of research work in tuberculosis was presented to the Committee on Medical Research of the National Tuberculosis Association in December, 1943, the response by members of the Committee was most enthusiastic. Some expressed the opinion that similar plans could well be formulated and executed by other local or state associations throughout the country, and comments concerning the California plans were most encouraging.

In this connection, it may not be out of place to recall that, in the judgment of experienced investigators, the accomplishments in research on tuberculosis so ably initiated and guided by Dr. William Charles White have been fundamentally of great value. A great deal has been accomplished with a relatively small investment. Everybody interested in tuberculosis and connected with the movement to suppress the infection and the disease, will read with keen satisfaction the splendid summary by Dorothy White Wilson: "Twenty Years of Medical Research," National Tuberculosis Association, 1943.

RESEARCH STUDIES CITED

Through the courtesy of the former President, Dr. Chesley Bush, the speaker became a member of the Medical Research Committee. Thus, it is only proper that a brief report on the problems which were discussed by the Medical Research Committee at the meeting in New York, December 9 and 10, 1943, should be presented.

(1) The *minimal lesion study*, from the standpoint of prognosis, type of treatment and to salvage manpower both for military and industrial needs, was considered most pressing. It is being pursued along five different avenues: (a) A study of 10,000 cases in the New York area to determine the subsequent behavior of minimal lesions characteristic of reinfection of pulmonary tuberculosis as detected in Selectees; to determine if such lesions can be classified as acceptable for military service on the basis of x-ray lesions with history and physical findings, and to assist the Surgeon General's Office in making a reasonable disposition of cases of the above type. (b) An intensive and extensive investigation of the minimal lesion as it develops among student nurses. This research is under the direction of Dr. Carroll E. Palmer of the National Institute of Health. Thus far, 38 nursing schools are participating in this study in 10 cities with approximately 3,000 nurses enrolled. It is planned to extend the study to California in the near future. (c) A third study deals with the reëxamination of the data compiled under the direction of Dr. J. D. Aronson on the value of B.C.G. vaccination of American Indians. In this research 1,000 cases vaccinated and 1,000 controls are being followed by x-ray and tuberculin tests. (d) The minimal lesions are being studied by the U. S. Army Medical Corps in cases of tuberculosis which have arisen since induction. (e) An attempt is being made to recover in the urine and serum of infected animals fractions of the tubercle bacillus to determine, if they have any prognostic value. No test of prognostic value has yet been devised.

STANDARD DRUG TEST NEEDED

(2) *Chemotherapy of Tuberculosis:* In view of the great achievement in the realm of the chemotherapy, even chemoprophylaxis of many acute infectious diseases, it is imperative that a national machinery be organized to provide and determine standard methods for testing drugs. A subcommittee, under Dr. L. U. Gardner, is engaged with the formulation of a program. In time it may be advisable to set up and financially support several centers in which the proper evaluation of promising drugs may be carried out. California should make a bid for the establishment of such a research center. To search for a cure in tuberculosis requires patience; the road is long and tortuous, full of pitfalls and disappointments. Indeed, it is doubtful if methods followed for the acute diseases are necessarily applicable to a chronic disease such as tuberculosis.

"DIASONE" PUBLICITY UNFORTUNATE

It is most unfortunate, in fact criminal, that the drug "diasone" has received nationwide publicity that it does not deserve. The chemical formula of this drug is very similar to that of "promin." In the digestive tract, both drugs break down to "diaminodiphenylsulfone," and both produce in animals haemolytic anemia with active blood regeneration. "Diasone" is slowly excreted, and consequently toxic skin reactions in form of fatal (one case) exfoliative dermatitis have been reported. Both in experimental animals and in clinical tuberculosis, "promin" has shown much greater efficacy than "diasone." According to reports, the improvements reported by Dr. Petters are not well substantiated. His criteria have not been adequate. Moreover, cavities in some patients which closed have now reopened, and other patients have developed recurrent disease while taking "diasone." Finally, definite spread of tuberculosis on patients taking full doses of "diasone" has occurred. Patients taking "promin" have not shown these complications.

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* From the George Williams Hooper Foundation, University of California.

Synopsis of a paper read before the California Trudeau Society, Los Angeles, March 29, 1944.

In view of these facts, it is important to emphasize again that those who have taken the Hippocratian Oath should not experiment with drugs or biologics until the research workers are in accord with regard to the principles involved, and have proved by animal tests that the preparations are effective, and produce no harm on prolonged administration. "Diasone" does not fulfill these prerequisites.

Third and Parnassus Medical Centre.

EXPERIMENTS IN THE CHEMOTHERAPY OF TUBERCULOSIS*

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CHEMOTHERAPY in the field of tuberculosis has lagged behind chemotherapy of other bacterial infections. The reasons for this are several:

1. Tuberculosis is a more complex disease than other infections, which makes chemotherapy more difficult to evaluate. Unlike other infectious agents, the tubercle bacillus produces protean pathological lesions, depending upon allergy, environmental and genetic factors, as well as upon dosage and virulence. The infection in animals lasts many months, which makes experimentation tedious and costly.

2. No standard method or technique of evaluating new chemicals for the treatment of tuberculosis has been developed. The strain of guinea pigs, as well as the dosage and virulence of tubercle bacilli, varies with each laboratory. The type of tuberculosis seen in guinea pigs is in some ways unlike clinical tuberculosis. In guinea pigs tuberculosis is a more rapidly fatal generalized disease, without the same tendency toward periodic spontaneous regressions, or localizations of pathology as seen in patients.

Guinea pigs may react differently than patients to drugs, relative both to dosage and therapeutic effect. This was the case with promin; when treated with this drug, the guinea pig will tolerate relatively larger dosage orally, and will respond therapeutically better than patients. Theoretically, one would expect the type of tuberculosis seen in patients to respond more readily to treatment than the disseminated type of tuberculosis seen in guinea pigs.

LOW TOXICITY AN ESSENTIAL

The following are the requirements of a new therapeutic compound.

1. The chemical must be low in toxicity. It would be futile to start with compounds high in toxicity, such as the mercurials. Some twenty years ago DeWitt tested a large number of organic mercurials on tuberculosis in guinea pigs. Although they showed some therapeutic effect, they had to be abandoned because of their high toxicity.
2. The chemicals must be nonirritating.
3. They must, to a certain degree, be soluble in water or lipids.
4. They should be compatible with serum.
5. The chemicals should be bacteriostatic in vitro.
6. The compounds should finally be effective in the animal body.

The following is the sequence of testing new compounds.

1. In vitro bacteriostatic action in synthetic media (without serum).
2. In vitro bacteriostatic action in serum. As most of the new chemicals, which are effective without serum, do not show bacteriostatic action in the presence of serum, this test permits us to screen out a large number of compounds rapidly, without resorting to the costly animal procedures.
3. Toxicity in guinea pigs.
4. Therapeutic effect in guinea pigs.
5. Pharmacology of the drug.

NINETY DERIVATIVES TESTED

The author has tested some ninety derivatives of benzophenone for their tuberculostatic effect in vitro. An effort was made to determine the relation between chemical structure and bacteriostatic action. The parent compound, benzophenone, has the advantage of being low in toxicity and of showing a moderately high bacteriostatic action. The following derivatives of benzophenone increased the bacteriostatic effect :-4-chloro; 2-chloro; 2, 4'dichloro; 2-iodo; 4-methyl; 4-methoxy; 4-ethoxy; and thiobenzophenone. Among the many derivatives which decreased the bacteriostatic effect were :-3-chloro; 2, 5 dichloro; 4-ethyl; 4-hydroxy; 4-amino; and 4-nitro. It was not possible to find a definite chemical pattern in the relationship between chemical structure and tuberculostatic action. However, if the results are analyzed on the physico-chemical properties of the compounds, certain patterns were discernible, such as an optimal lipid-water solubility ratio. If guiding principles, such as the above, can be evolved, chemotherapy can proceed by more orderly and logical methods, than that of the hit-and-miss methods of the past.

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* From the Harold Brunn Research Institute, Mt. Zion Hospital, San Francisco. Synopsis of a paper read before the California Trudeau Society, Los Angeles, March 29, 1944. Published in full in the American Review of Tuberculosis, June, 1944.

IMMUNITY PROBLEMS IN TUBERCULOSIS*

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DURING the past year we have been employing isolated constituents of the human

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* From the Department of Bacteriology and Experimental Pathology, School of Medicine, Stanford University.

Read before the California Trudeau Society, Los Angeles, March 29, 1944.

The work on which this report is based has been aided by grants from the California Tuberculosis Association and from the Fluid Research Fund of the School of Medicine, Stanford University.

tubercle bacillus in an attempt to clarify the immunological sequence of events in tuberculosis. We have considered that a rational experimental approach to this end might be the following: first, to try to elicit a serologic or allergic reaction peculiar to the immune animal and directed against one of the isolated antigenic factors of the bacillus; secondly, to attempt to induce resistance to infection by the use of such isolated bacterial components.

To this end we have concentrated our attention on the possible rôle of the polysaccharide of the tubercle bacillus in inducing immunity, as well as in indicating the existence of immunity in adequately-vaccinated animals. Although the carbohydrate has been chosen as the focal point of our experiments, the effects of other major substances of the organism—protein and lipid—have also received attention.

BACKGROUND FOR STUDY

The background for this study is provided by a plethora of experimental, clinical and pathological observations which indicate that a tuberculous infection resulting from secondary exposure to the bacillus differs from the primary type of infection in its tendency to localization. Until about a decade ago this localization of the secondary infection was generally considered to be a function of allergic reactivity engendered by previous contact with the tubercle bacillus. Krause and his collaborators[1] laid an experimental foundation for this view. In recent years, however, there has been an increasing divergence from this opinion, instigated to a large extent by the work of Rich and McCordock.[2] The observations of these investigators failed to support the conception that immunity to tuberculosis rests on an allergic basis.

The allergic state which results from contact with the tubercle bacillus has long been known to be caused by, and to be directed against, the protein of this bacterium. A second component of the organism, the lipid, is responsible for the cellular organization characteristic of the tubercle. The activity of the major carbohydrate is not known other than that large amounts of it are not toxic for either normal or tuberculous animals, and that its injection results in polymorphonuclear exudation.

We have chosen the carbohydrate as the central theme of our work for several reasons. In the first place, it has been demonstrated, in connection with a variety of bacteria, that carbohydrates are important antigens in stimulating protective immunity. Secondly, the tubercle bacillus possesses a considerable amount of carbohydrate which is serologically active, and concerning which there is little immunologic information. Finally, if this substance is found to play an important part in eliciting immunity to tuberculosis, the allergic state (to the protein) would be shown to be unnecessary to the welfare of the infected body, and the proposal that it be eliminated by proper treatment would rest on a firm basis.

B.C.G. VACCINATION IN ANIMALS

In the present stage of this work we have a number of impressions derived from observations of the human bacillary infection in guinea pigs and the bovine bacillary infection in rabbits. Some of these animals had been vaccinated with B.C.G., others with heat-killed or defatted bacillary vaccine before infection. Controls received the infecting organisms only. Experimental infection was routinely established by subcutaneous inoculation in the inguinal area. In all cases information has been sought concerning serologic responses and skin reactions to isolated antigens, throughout the periods of vaccination and infection.

We have found that in guinea pigs, as anticipated, the B.C.G. vaccine engenders a relative immunity to subsequent infection. It has been our experience that, quite aside from the survival period, this immunity is manifested by a visceral distribution of the disease which differs from that seen in unvaccinated animals, or in guinea pigs vaccinated with ineffective preparations (such as defatted tubercle bacilli). Resistant guinea pigs develop extensive pulmonary tuberculosis. If life has been sufficiently prolonged, this is marked by cavitation and advanced fibrosis. On the other hand, the liver and spleen are relatively spared. This picture is in sharp contrast to that seen in the uninfluenced infection in which the usual findings include marked hepatic and splenic involvement, and relatively mild pulmonary disease.

LOCALIZATION OF INFECTION

This visceral distribution has been so constantly associated with the infection in animals vaccinated with B.C.G., even in those cases where survival was not significantly prolonged over controls, that, at the present time, we look upon it as a pathological indicator of immunity; that is, a sort of measure of the ability of the body to localize the infection to the lungs, the first vascular filter-bed through which the organisms pass after they have entered the blood from the lymphatic system.

We are prepared to change our views, should contradictory evidence appear in our later protocols, but at the present time we believe this situation to be comparable to the type of localized activity seen in human beings with secondary infection. Our guinea pigs, it should be noted, are infected with numbers of organisms probably far greater than the number likely to be concerned in a spontaneous infection, so that even those which are relatively immune may die of advanced pulmonary infection without a protracted survival period.

SEROLOGIC RESPONSE AGAINST PROTEIN

Now, as to our observations concerning the correlation of the immunologic responses to isolated bacillary antigens with the clinical and pathological picture of immunity:

1. *The Protein*

We have found that the usual serologic response of both rabbits and guinea pigs to vaccination with any of the bacterial antigens *per se*, or to infection, is directed against the protein of the organism. We can definitely state, as has been pointed out by others in the past, that the degree of this response, and indeed its presence or absence, can in no way be related to the existence of immunity. In many instances, animals vaccinated with ineffective bacillary suspensions (heat-killed or defatted bacilli) showed high titers of antiprotein antibody on the day of infection, but no subsequent resistance at all, while others immunized with a more effective vaccine might have no detectable antibody of this nature, but a good degree of immunity as measured by survival time and autopsy findings.

In a less clear-cut way this has been true also of skin reactivity to protein. We should like, and are in the process of obtaining, much more evidence regarding the latter point before making a definite commitment; but up to the present time we have not been impressed by the relationship of allergic reactivity at the time of infection with subsequent immunity.

2. *The Lipid*

The phosphatide, the chloroform soluble wax and the "firmly bound lipid" obtained from human tubercle bacilli have yielded no positive reactions with the sera of vaccinated or infected guinea pigs.

3. *The Carbohydrate*

With rare exceptions, guinea pigs have shown no serologic antibody directed against the carbohydrate, whether or not the animal proved to be immune to infection. We may interpolate the conclusion here that resistance to tuberculosis in guinea pigs is not marked by any demonstrable reactivity of the serum, since the antiprotein antibody has been found to be unrelated to immunity, and no other antibody reactivity has been evinced by the most elaborate methods available at the present time, including complement fixation, precipitation and various kinds of collodion-agglutination tests.

OCCURRENCE OF SKIN REACTIONS

Certain rabbits do form anticarbohydrate antibody following vaccination with B.C.G., but we have insufficient information concerning the eventual immunity in these animals to attempt a correlation at this time.

During the past several years there have been occasional reports[3, 4, 5, 6] concerning the occurrence of skin reactions to the injection of tubercle bacillary carbohydrate in tuberculous individuals or animals. The preponderance of this work has been done in human beings, which is unfortunate from the standpoint of basic interpretation. We have been carrying out routine intradermal tests with carbohydrate in all our animals, coincidentally with O.T. or P.P.D. tests, during the period of vaccination and infection. We have been impressed with the fact that tissue reactivity to carbohydrate may bear no relationship to the degree of reactivity displayed at the same time to tuberculin. We are expending considerable effort in attempting to determine whether or not such tissue reactivity is correlated with immunity to tuberculosis. Were this the case, it would be necessary to reëvaluate the interpretation of positive tuberculin or P.P.D. reactions, since these materials contain appreciable amounts of carbohydrate as well as protein.

Our analyses of four samples of tuberculin and P.P.D., which we have been employing, have shown in all cases that of the total bacillary substance present, two-thirds is protein and one-third is carbohydrate. This amount of carbohydrate may also influence the results which have been reported to follow desensitization of animals with tuberculin preparations, namely, a diffuse growth of large numbers of bacilli throughout the lungs. It is well to entertain the possibility, until further evidence is available, that in addition to desensitization to protein contained in the tuberculin, there may be a "deimmunization" or negative phase induction brought about by the carbohydrate.

The crucial test of the rôle which any one of the bacillary components might play in immunity to tuberculosis would be the effectiveness of such a substance in actively stimulating immunity. At the present time we are observing a group of animals, some of which were vaccinated with carbohydrate, others with other isolated bacillary antigens. We have begun to accumulate information concerning the survival periods and pathological changes in these animals, but these observations have thus far been too limited to warrant a report now.

Stanford University.

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"Books—to judicious compilers, are useful; to particular arts and professions, absolutely necessary; to men of real science they are tools."—*Samuel Johnson.*

THE AMERICAN LEGION AND PLANS FOR THE CONTROL OF TUBERCULOSIS AMONG VETERANS*

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Los Angeles

FIVE questions regarding care of the tuberculous veteran have been submitted to me and I would like to offer comment upon them.

The first reads:

Has the Veteran's Bureau handled the problem of World War I?

First, let us call the Federal Agency that cares for veterans by its current name. The old Veteran's Bureau went out of existence in 1930, when it was consolidated with other agencies into a much more comprehensive agency known as the Veteran's Administration. Next I would like to insert the word "adequately" so that the question will read: Has the Veteran's Administration adequately handled the World War I problem? My answer is that it has done a good job under all of the circumstances, and with the tools at its disposal. It has been called to your attention that the Veteran's Administration is a government agency, that it can do only those things possible under the laws passed by the Congress, and under the appropriations provided by that body. It has never had unlimited authority to enter upon a general program, and most of the time its facilities have been inadequate to meet the demand for hospitalization. In the early days its equipment was anything but satisfactory. From time to time it has experienced serious professional personnel problems due to limitations as to salary levels and to Civil Service regulations.

Its primary responsibility has been to the man whose disability was considered to be Service-connected under a complicated set of Regulations, but in later years it has been allowed to grant hospitalization without reference to cause or beginning date of activity to men who were unable to pay for private care.

It has provided compensation on a $100.00 per month scale to the Service-Connected Case, and on a $40.00 basis to the Non-Service Case, reducing those amounts to $20.00 and $8.00 respectively when a man without dependents was hospitalized.

It has built up a system of hospitals throughout the country, now adequately equipped and staffed, generally speaking; and had the present laws and facilities been available immediately after World War I, the story and the reputation of the Veteran's Administration would be quite different. It has received little recognition from the public for its steadily improving service.

Coming to the second question:

2. *Has the tuberculous Veteran coöperated?*

My answer is: Not to the satisfaction of the American Legion; *but*—we had little to offer in the early days. Would you have accepted hospitalization, over a long period, in an old army cantonment that was not even kept in adequate repair, built of boards and battens, and located on a mesa thirty miles from nowhere? With no provision for your family, financial or otherwise, or with your compensation payments, which were the only support for your family, subject to change or complete withdrawal every few months? Those conditions have been remedied, but the memory lingers on.

May I also observe in passing that too little attention has been paid by all of us concerned to the personal problems of the men themselves. The solution of some of those problems might have made so-called coöperation easy, instead of difficult or impossible. Often we did not sell. We told. We did not educate. We demanded. We forgot that the men had just been released from strict discipline which had been abhorent to them. They wanted no more of it regardless of circumstances.

Question 3. *Is the World War II man beginning the same old routine?*

He is starting from the same place, to reach the same objective, *but* he is on a paved road.

In the first place, he has had better care while in the Service at the hands of the Army or Navy than the World War I man had. He will have but one Government agency to deal with, one with 25 years of experience with his problems, that has a real medical program and real hospital facilities to offer. Already there is pending before the Congress a very large appropriation to extend those facilities, and there is every reason to expect its enactment into law.

After World War I a request for a man's service and medical record by the Veteran's Bureau brought a sentence or two on the back of the request blank from the Adjutant General's Office or the Bureau of Medicine or Surgery. Today, the Army automatically forwards its complete Clinical Records to the Veteran's Administration and the Navy sends a carbon copy of its Medical Summary, immediately upon the man's discharge from hospital. Thus the original pension-rating is based on all of the facts, and the man knows where he stands. If any dispute arises he can have, for the asking, the advice and help of the trained and experienced officials of the American Legion or the Red Cross. No such service was available to the World War I Man at his discharge.

4. *How can matters be improved?*

An excellent suggestion has been made: that disability compensation over a certain amount be impounded pending discharge upon medical approval—this to offset the present tendency of the patient to leave against medical advice, in order to collect full compensation which is payable to single veterans not hospitalized. But this would require legislation which would be difficult to secure from the Congress as it would have to apply to other types of cases than the tuberculous.

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* From the Department of California Service Office, American Legion, Los Angeles.

Read before the California Trudeau Society and the California Tuberculosis and Health Association, in a symposium on Future Plans for the Control of Tuberculosis Among Veterans, Los Angeles, March 29, 1944.

I am sure that the American Legion recognizes the fact that the tuberculous veteran is a public health problem, and that it agrees with the proposal that hospitalization be given whenever possible in the area in which the man resides. We will do what we can toward that end.

In closing, I have the same old suggestion—Education—but perhaps I have a new slant to offer.

The American Legion wants you to educate its officials and its members in this problem so that they may coöperate with you in its solution. With nearly 600 posts and 75,000 members, it reaches into every town and hamlet. Can't you use us? Our members are no longer boys. The average age is 49 years. When you talk about World War II men you are talking about their sons and daughters and their neighbors' children. You are also talking about nearly 150,000 Legion members who are themselves in service again—the so-called Retreads. We would be most happy to meet with your officials or committees to work out plans under your guidance.

TUBERCULOSIS SERVICE OF THE VETERANS' BUREAU*

Chesley Bush, M. D.
Livermore

I HOPE there will be a full and adequate discussion of this subject, because in my judgment this is the most important and pressing problem before tuberculosis organizations in North America today.

Recently I received a letter from one of our younger chest men, who is at present in the Army. He had taken some tuberculous soldiers to a Veterans' hospital for discharge from the Army. In the letter he reviewed the future in store for these men. He stated that about half would check themselves out of the hospital within a week, largely because, if they had no dependents, they would be paid $15 a month in the hospital and $100 a month outside. When outside, they would rove the country spreading infection. If they stayed in the hospital, they would be mixed with the chronic holdovers of the last war, who are more or less a discouraged lot, not too coöperative with their medical care. The letter ended with a plea to do something about this new group which will loom large on the horizon of this country as the years proceed—especially to take the profit motive out of the care of tuberculosis. "Congress should do something about it," he wrote, "and the N.T.A. could well lead the fight. They have the money and the prestige."

Since World War I, there has been no thought save to provide the tuberculous veteran with every aid and help to get well. Splendid hospitals have been provided, staffed with three and four times the number of doctors usually carried by civilian sanatoria of the same type, and with twice the nursing and maintenance staff. Eight million dollars was spent in 1942, alone, for maintenance of these hospitals. About one billion dollars has been spent since World War I for the tuberculous veteran.

Have the results warranted the expenditures? Has the system proven satisfactory? The majority of physicians and others familiar with the tuberculosis problem say NO! Louis I. Dublin points out that the system can be classed as a failure, and if continued, may seriously interfere with the control of tuberculosis in the general population of the country. He states that, in a recent survey, 3 per cent only of Veterans were classified in one year as arrested, apparently arrested or quiescent; and that in previous years (since 1929), comparable figures were never more than 6 per cent with figures of civilian hospitals running from 30 to 60 per cent. What then is the basic cause of this lack of control of the tuberculous veteran?

The answer seems to be that the care of tuberculosis is not that of a disease requiring a specific medical or surgical treatment, but a slow and prolonged program of life requiring all the aids and adjustments that proper psychological care can contribute. In carrying this out up to now, every psychological handicap has been placed in the way of adequate veterans' care, because of the following factors:

1. To pay a patient to be ill and penalize him economically to become well offers no psychological inducement for him to become well. Tuberculosis is such a chronic disease, often without symptoms, that it may become an economic asset under these conditions.

2. To pay a patient more to stay out of a hospital does not induce him to stay in, if necessary.

3. To pay a patient more to stay in a hospital does not induce him to leave, when such would be beneficial to himself and his family.

It is apparently not possible to set up a financial program for tuberculosis which fits all other medical, mental, and surgical conditions of the post-war veteran; but tuberculosis should have a program of its own, fitted to the needs of tuberculosis treatment and public health control. This program would give the physician some power and responsibility of decision, and would tend thereby to increase the interest of the trained man to give his time and attention to the tuberculous veteran. This program should not stop at the veteran himself, but should tie in with the proper medical care and protection of his family.

Because of the public health aspects of tuberculosis, and because of the need of boosting the morale and character of the physicians now dealing with tuberculosis in the Veterans' Bureau, it has been suggested that a future plan be set in effect to draw the physicians of the Veterans' Bureau, who deal with tuberculosis, from the U. S. Public Health Service.

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* From Arroyo Del Valle Sanatorium, Livermore.
Presented before the California Trudeau Society and the California Tuberculosis and Health Association in discussion at a symposium on Future Plans for the Control of Tuberculosis Among Veterans, Los Angeles, March 29, 1944. For Resolution, see page 93.

In conclusion, might we say that:

1. The remunerations of the tuberculous veteran should be changed and coördinated in a program that will

a. Retain patient in hospital as long as necessary,

b. Give a bonus for discharge, and a

c. Stimulation to carry on a proper follow-up.

2. Medical personnel be improved.

a. Change in above regulations will help morale of medical staff.

b. Draw new personnel for tuberculosis hospitals from U. S. Public Health Service.

3. We should propagandize the country, the Congress, the American Legion and other organizations to the need of change, from the N.T.A. on the top to the tiniest local tuberculosis association in the county.

Tuberculosis organizations have this year taken twelve million dollars from the country. This contribution can be justified only if a sincere attempt is made to improve this situation at this critical time.

Arroya del Valle.

SOME NEWER ASPECTS OF RHEUMATIC FEVER*

Louis E. Martin, M. D.
Los Angeles

DURING the early years in the heart clinic of the Children's Hospital in Los Angeles, we saw a steadily increasing number of children with unquestioned rheumatic heart disease, but were puzzled by the statement that several experienced pediatricians had never seen acute rheumatic fever in private practice. Most of these children were born in Los Angeles, very few were indigents, some were new arrivals. What accounted for this discrepancy? Was it a disease purely of the public-ward child from across the tracks or were other cases escaping diagnosis?

Acute rheumatic fever has an onset like an infection in 85 per cent of the cases, according to Cohn and Lingg in their recent review of 12,000 cases. It has an active phase which more or less quickly passes over into a latent phase, from which it readily can be reactivated. The duration of the total phase is, on the average, about five years, before it passes into an inactive phase. Reactivation, recurrence or recrudescence from this inactive phase is still possible. With each reactivation of the disease, the possibility of increased heart damage becomes more probable. Rheumatic heart disease presupposes that the individual has had sometime in the past an active form of the disease, even though history fails to elicit symptoms.

EVOLUTION OF PRESENT CONCEPT SLOW

The evolution of our modern concept of this disease has been very slow. Coburn has postulated the idea that rheumatic fever may not necessarily be a new or unknown infection set off or incited by the streptococcus, acting as a trigger or percussion cap, but that it might represent a state of chronic streptococcic infection with only partial immunity or faulty immunity to the disease. This parallels the older hypothesis of Swift, that a persistence of a streptococcic infection in rheumatic fever sufferers might set up an allergic-like activity in his tissues. The recent work of T. Duckett Jones, in which he was able to predict outbreaks of acute rheumatic fever in the Eastern Naval Training stations by finding an increased count of Group A organisms in the air about these stations, again forges an important link in our concept.

It is well known that the interval of time during which hemolytic streptococci are found in the throat in acute tonsillitis and scarlet fever is identical, and that the time interval before the appearance of acute arthritis, carditis or acute nephritis is also identical—averaging roughly 18 days. John R. Paul, in his excellent and all-comprehensive monograph on the etiology of rheumatic fever, suggests from this that perhaps the rheumatic child may be, for hereditary or acquired reasons, less capable of handling an acute streptococcal infection than the nonrheumatic. He believes that there is yet much to be explained in the streptococcal conception, but adds that the apparent protection of rheumatic children from recurrences by the prophylactic use of sulfanilamide, as reported recently by Ann Kuttner, in the Modern Concepts of Cardio-Vascular Disease, certainly gives support to this concept.

AVERAGE AGE OF ONSET IS SEVENTH YEAR

Alfred Cohn, in his recently completed, 15-year study of the natural history of rheumatic fever, brings out some interesting points relative to the age of onset. He states that the disease may start at any age, but the average age of onset is the seventh or eighth year. He emphasizes that the onset in certain age groups is associated with symptoms which tend to fall into definite patterns. In those acquiring the disease before the tenth year, vague muscle and joint pains, polyarthritis, chorea and carditis are found singly or combined in 85 per cent of the cases. Around the age of 5, the tendency is to vague and indefinite muscle and joint pains. At 8 years, the peak for chorea as initial symptom is very sharp. Before the 20th year muscle and joint pains, and chorea are found in about 20 per cent, but after the 20th year these forms tend to drop out, leaving only polyarthritis and carditis as initial symptoms. Fewer than 5 per cent have initial onset after the 40th year. Carditis, as an initial symptom, reaches a peak at the 6th year, polyarthritis between the 6th and 8th years.

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[*] From the Los Angeles Children's Hospital.
Synopsis of a paper read before the California Tuberculosis and Health Association, Los Angeles, March 29, 1944.

Much has been written of the existence of rheumatic families in whom, or rather in the offspring of whom, rheumatic fever is more prone to occur. With the advent of our newer knowledge of the infectious possibilities of the disease, it was first thought that this explained familial occurrence. The careful genetic studies of Mae G. Wilson, however, point out that the Mendelian law is followed with amazing accuracy, and it must be concluded that the soil of the host is an important factor.

SYMPTOMS MILD IN SOUTHERN CALIFORNIA

To one who comes to Southern California from the northeast, it may appear on the surface that there is less rheumatic fever here than really exists because of the mildness of the symptoms. Few children here give the classical textbook histories or signs of the active acute phase. Joints are seldom red, swollen, hot and tender or, if they are on hospital admission, they rarely persist long enough to teach a class of students from them.

Alexander T. Martin of New York emphasizes, from a 22 year experience covering 1,438 rheumatic children, the high incidence of the disease. He points out that rheumatic heart disease constitutes 25 per cent of all deaths from heart disease, accounting for 40,000 deaths yearly at an average age of 30 years. Roughly, 1 per cent of all school children or about 200,000 are afflicted between the ages of 5 and 19.

The common onset of rheumatic fever is from the fifth to the fifteenth year, but, remember, it has been discovered in utero, we have seen it in two-year olds, I now have a young woman down with her first attack at 38, and a man of 39 in the first recurrence since his original attack in Winnipeg at nine years. The first five years from the original attack are the critical years during which most recurrences and deaths occur. If the average onset is at the 7th or 8th year, this five-year critical period may account for the seeming decrease after puberty rather than any sudden change in resistance to infection. To be sure, recurrences after puberty are less common, and the monocyclic form is more often to be expected. Deaths from the disease may or may not be associated with congestive failure; more often the latter plays only a minor rôle in the child. On the other hand, congestive failure in the child is almost invariably associated with a flare-up of the disease, and often this factor should receive the major attention.

DIAGNOSIS OFTEN DIFFICULT

Diagnosis offers no problem when the child presents the outstanding symptoms of polyarthritis, carditis, severe leg or muscle pains, or chorea, and exhibits high fever, sweats, leucocytosis and prostration. The more difficult, and demanding of closer scrutiny, is that child observed to tire more easily, who remains thin and fails to gain weight, or who has frequent nosebleeds and marked pallor. He may run bouts of slight, unexplained fever, fleeting pains in muscles and about joints so trivial that they may not be mentioned, unless patient or parents are closely quizzed. Irritability, nervousness, change in disposition should make one suspicious. Very frequent colds, so-called feverish colds, and sore throats may be the only symptoms less alert parents may have observed. These were the only symptom in 9 per cent over a four-year period at the Children's Hospital in Los Angeles. It is truly a misfortune we still have no specific test of the presence of the infection comparable to the Widal test; yet the presence with any of the above symptoms of slight fever, leucocytosis, increased and persistently rapid heart-rate, and a persistently elevated erythrocyte sedimentation rate, should make one consider the diagnosis of rheumatic fever most likely. To be sure, it at present is still an exclusion diagnosis. Demonstrable evidence of valvulitis rarely occurs early in the first attack, although the heart is usually involved. The appearance of an apical systolic murmur or a gallop rhythm, or a prolongation of the PR interval, will confirm the diagnosis. True polyarthritis, subcutaneous nodules or a pericarditis may later appear. Erythema multiforme is frequently missed because of the transient duration of this phenomenon.

Occasionally, one sees acute abdominal pain as a first symptom, many of these coming to us after the surgeon has removed a normal appendix. Not a few are admitted as poliomyelitis suspects. All so-called growing pains should be regarded as rheumatic, unless some definite cause, such as faulty arches or bad posture, can justify a less serious diagnosis. The minor degrees of chorea are rarely missed if the observer remembers that the choreic movement is purposeless, involuntary, sudden and nonrhythmic and, most commonly, involves the diaphragm early. The attitude towards chorea is at present undergoing some revision. When it occurs in pure form, devoid of any of the other symptoms of rheumatic fever, the heart is rarely found damaged, even though it may recur. The sedimentation rate in this condition remains normal unless some other evidence of rheumatic fever is found, and likewise leucocytosis is absent.

SEDIMENTATION RATE NOT A SURE GUIDE

Right here, may I offer a word of caution about the erythrocyte sedimentation rate. It remains one of our most useful aids in following the child or adult with rheumatic fever; it is, however, a nonspecific test. It is exaggerated in anaemia, it is normal in pure chorea and in the very acutely-ill patient with carditis and right ventricular failure, and engorged liver, it remains normal or less than normal—rising only when decompensation has disappeared. It becomes more valuable as our most reliable guide in knowing when the latent phase has passed into the inactive phase.

It is my belief that the factor of secondary anaemia, which is such a common finding in rheumatic fever, is emphasized too lttle. It is my feeling that the more profound the anaemia, the more extensive and rapidly progressive will be the heart damage.

The earlier the diagnosis, the better will be the prognosis if proper care is instituted. Few die in the first attack. The immediate care, absolute bed rest, salicylates, opiates or sedatives to maintain rest, digitalis or cedilanid if needed, iron. adequate diet and vitamins are well known to you all. One word of caution: it is universally agreed that once rheumatic fever has begun, all the present sulfonamides are definitely contra-indicated and serve to do harm during the active phase.

At present, our best mode of avoiding recurrences is to keep the patient screened in so far as possible from streptococcus infection until the most critical 5 years' period is over.

Complete bed rest during the active acute stage is imperative, and should continue throughout the latent stage until complete inactivity is reached.

When is the disease inactive? When all symptoms and signs of the disease have disappeared, together with a return to normal of the white-blood cell count, the hemoglobin and the red-blood cell count, the sedimentation rate and the temperature. When the appetite and weight zoom upward, together with the zest and exuberance of the healthy child, when nodules have all gone and the heart-rate drops to normal, and the electrocardiogram shows that conduction time has returned to near normal, then only may one begin to allow a graduated measure of activity.

1136 West Sixth Street.

PERSPECTIVES AND TRENDS IN TUBERCULOSIS*

HENRY STUART WILLIS, M.D.
Northville, Michigan

A FEW high spots stand out in the development of our knowledge of tuberculosis. The first one is featured by Laennec, who pointed to the kinship between histological tubercle, the cavity and all the stages between. Villemin furnished unquestionable proof that tuberculosis was infectious, and Koch's discovery of the tubercle bacillus laid the foundation for a great deal of spade work that has been done in the modern era. Pirquet's tuberculin test brought knowledge that tuberculous infection is widespread among us, and the coming of the x-ray made the scheme of modern treatment possible.

The intelligent use of bed rest, popularized by Trudeau, and the advent of collapse therapy, combined with intelligent use of bed rest, have brought us to our present rather favorable situation.

What are the trends in treatment of this disease today? Pneumothorax has been used extensively for thirty years, during which the range in indications, technique, complications and results has been wide. Its use, misuse and abuse have brought it into serious question. Those who use it intelligently find it highly valuable, but they feel the need of a new set of criteria. They would sharpen its indications and point out anew its contraindications, and would employ pneumonolysis increasingly.

NEW CRITERIA FOR USE OF SURGERY NEEDED

It was a great day when the surgeon took his place in the council chamber of tuberculosis physicians. He gave a practical turn to the treatment and added procedures, neglect of which would be tantamount to malpractice. Some surgeons would remove lobes or lungs for tuberculosis. This is a question that should receive and is receiving careful scrutiny.

Surgeon and physician alike may have overplayed the issue in stressing sputum conversion and cavity closure as the *only* major desiderata. Physiological and functional evaluation, prior to operation, are of greatest importance and should be used more extensively. The physiological laboratory should have as prominent a place in the sanatorium menage as the pathological laboratory.

The laboratory has grown with the years and is now usually a well-run integral division of the sanatorium. It yields tubercle bacilli in the greatest variety of secretions and excretions of tuberculous persons, and in circumstances where its presence had only been suspected before. It is the duty of clinician, however, to evaluate the situation in respect to the significance of bacilli. He must take into account the intelligence of the patient, his postdischarge plans and his family, the type of disease, the kind of collapse and the competence of the healing process as shown by x-ray.

PARTICIPATION OF LAYMEN

Sanatoria and the tuberculosis effort in general challenge clinician and pathologist to study the many questions that still remain unanswered. Chemotherapy clamors for attention. We still have a sorry showing in the early diagnosis and treatment of complications. We are too often careless about an adequate dietary for tuberculous patients.

Laymen may well participate in the general battle against tuberculosis. In two particular fields at present there is urgent opportunity for the layman to become a yeoman. These two fields concern, first, the legislative situation which tends more and more to make tuberculosis a compensable disease and, as a side effect, to lessen the expatient's opportunity to obtain employment; and, secondly, rehabilitation for the tuberculous, which is in great need of intelligent sponsorship. It no longer suffices to get the patient well. He should be prepared for useful work. This field of endeavor challenges the interest and coöperation of public and private agencies.

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* From the William H. Maybury Sanatorium (Detroit Tuberculosis Sanatorium) Northville, Mich.

Synopsis of a paper read before the California Trudeau Society and the California Tuberculosis and Health Association, Los Angeles, March 30, 1944.

RESOLUTION CONCERNING THE CARE OF TUBERCULOUS VETERANS*

THE resolution which follows was adopted by the California Trudeau Society and the California Tuberculosis and Health Association in a symposium on Future Plans for the Control of Tuberculosis, Los Angeles, March 29, 1944.

Resolved, That we, the members of the California Tuberculosis and Health Association, in convention assembled, realize the seriousness of the tuberculosis problem involved in our War Veterans;

That we recognize that this Veterans' Facility as at present constituted is seriously limited in attempting to give medical treatment to cure these patients;

That we agree in principle with the solution offered by Dr. Chesley Bush in his report as presented at this meeting;

That we recognize that the National Tuberculosis Association has this matter under consideration in an attempt to reach a satisfactory solution;

That we instruct this Board of Directors of the California Tuberculosis and Health Association to communicate to the National Tuberculosis Association our desire that the program as outlined by Doctor Bush be given their serious consideration at their Annual Meeting in May, 1944 to the end that on a National, State, and local level adequate discussion be stimulated that will lead to effective action in helping the individual tuberculous Veteran to achieve a cure of his disease.

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* Re: Resolution, see articles on pages 88-89.

VIRUS PNEUMONIA**

LIEUT. COL. RUSSEL V. LEE, M.C., A.U.S.
Santa Ana

FOR this audience it will not be necessary to review the fundamental features of the so-called "primary atypical pneumonia, etiology unknown," which we have come to believe, in the Army, is a very typical disease, and the etiology of which we believe we know. This disease is by all means the most common of the respiratory ailments with which we have had to deal, and is characterized by a rather typical picture, though, to be sure, it manifests itself in a wide variety of forms from the mildest, almost asymptomatic form to a very severe and even fatal illness.

We have had at Santa Ana about 2,500 cases of pneumonia, of which approximately 2,000 have been of the virus type. In this series, one patient has died. That patient, however, had his picture complicated by a concurrent encephalitis and myelitis. The description given is that of a disease in which the x-ray finds a consolidation in the lung, which is often very much greater than one would expect from the physical findings there. The clinical course of this condition is well known to you all, and is borne out by our observations. We have, however, been able to make a few observations which, perhaps, may be said to be original in that they are of a kind that the ordinary practitioner has no opportunity of making.

PNEUMONIA FOUND IN ROUTINE EXAMINATIONS

In the first place, we have encountered a group of men, newly processed for cadet training, in whom a considerable patch of pneumonia was discovered accidentally, that is, in the course of their routine x-ray examination for classification as cadet. These patients presented frequently a truly remarkable appearance, showing a large patch of pneumonia with an almost complete absence of symptoms, though, to be sure, upon close investigation it was usually found that they had had a bad cold for a while, or that they had been coughing; and, usually, when they were put into bed in the hospital, as was invariably done, they were found to be running a low grade fever. The problem of the differentiation of this condition from tuberculosis should be of particular interest to this audience. It is not infrequently that these patches of pneumonia are located at one apex or another, and, taken together with the patient's rather benign clinical picture, could readily be confused with an active tuberculosis. In fact, the x-ray men refused to make the differentiation until they had had an opportunity to reëxamine the patient after a lapse of from several days to two weeks. When, as usually happened in such cases, the shadow entirely cleared in the course of ten days' observation, the assumption that they were dealing with a virus type of pneumonia was justifiable. This group of asymptomatic cases, with significant amounts of pulmonary consolidation, deserves to be recognized as an entity, and, so far as I know, has not been previously described.

We were struck, as all others have been, with the migratory character of the consolidation in hundreds of instances, in watching it by x-ray moving from one part of the lung field to another while the original area cleared. The character of the sputum deserves mention, in that the bacterial flora is remarkably scanty. There seem to be fewer bacteria even than in normal saliva or bronchial mucous. With others we observed a strictly normal leukocyte count; and, corroborating other work, we found that approximately 70 per cent of the cases had positive cold agglutinin tests. The incidence of complications is really very low. Pleural pain is not uncommon, but real pleuritis with effusion is quite rare.

VARIETY OF CASES

There were two cases of empyema, but these were due to secondary infection by streptococci. There were about five cases of pleural effusion, which cleared spontaneously without aspiration. About six cases of bronchiectasis were observed, but we were not able to say definitely whether or not they preëxisted; though the assumption is that, having passed a rather strict physical examination previously, the bronchiectasis developed as a consequence of the disease.

** Read before the California Trudeau Society, Los Angeles, March 30, 1944.

The opinions and assertions contained herein are the private ones of the writer, and are not to be used as official or reflecting the views of the Army Department or the Army service at large.

There is another complication standing at the opposite end of the line from the early asymptomatic cases, which we had a unique opportunity to observe. This was a group of patients who developed a chronic form of the disease, in whom, so to speak, the virus smouldered, to be activated whenever they took physical exercise, producing symptomatic relapse, new patches of consolidation, and febrile episodes. Some of these chronic cases developed the typical picture of cardio-vascular asthenia, with increased pulse rates, sweating of the palms, and rather marked nervous instability. A group of these, numbering about twelve, persisted in their symptoms over a period of six to eleven months, and finally required discharge from the Army. This latter consequence of virus pneumonia also has been previously unrecognized, and it may be that some such serious virus infection of this sort, having, as we know it to have, a predilection for the central nervous system, could be really the underlying cause for the so-called cardio-vascular asthenia.

USE OF SULFONES

In the matter of treatment, our observations corroborated those of others, namely, that the sulfones have no effect upon the uncomplicated form of the disease. However, we watch the patients very carefully, and if they develop signs of secondary bacterial infection we do not hesitate to use sulfones, and, as a matter of fact, use them quite freely. We recognize a jump in the leukocyte count to anything above 11,000, or an occurrence of early pleurisy, or a change in the character of the sputum to a frankly purulent sputum, as evidence that such a secondary bacterial congestion has occurred. When this happens, we promptly give sulfones in full doses; and we feel many episodes which might have proven quite serious have been promptly terminated by such measures.

The most interesting therapeutic results we have obtained, however, have been from the use of convalescent serum. We make a practice of bleeding the convalescent patients and keeping on hand a pool of serum to be used in the more serious type of case. About 250 liters of serum have been so used in approximately 100 seriously-ill patients. In 50 per cent of the cases the results were spectacularly effective. In 25 per cent more the results were considered effective. In another 25 per cent the results were doubtful; but none of these patients died, and they were only given serum because they were thought by the attending physician to be seriously ill. I personally feel that ten of these men would have died without administration of the serum, and think that such serum pools should be set up and maintained in all places where a considerable number of patients with this disease may be expected, such as county and general hospitals, institutions for the aged and insane, etc., as well as in military hospitals where the opportunity for doing such a thing, of course, is very much better.

In résumé, therefore, I want to report 2,000 cases of virus pneumonia with one death, to call attention to the possibility of the existence of a considerable degree of consolidation of the lung from this disease without the patient being aware of being seriously ill, to note the possible connection between virus disease and the development of so-called cardio-vascular asthenia, and to report on the successful use of convalescent serum in a rather large series of seriously-ill patients.

Santa Ana Army Air Base.

FATE OF INFANTS OR VERY YOUNG CHILDREN WITH TUBERCULOSIS*

Gertrude F. Mitchell, M. D.
and
Henry Stuart Willis, M. D.
Northville, Michigan

TUBERCULOSIS is well known to produce a high mortality in the very young. Data on hospitalization, discharge and follow-up of 243 children below three years of age in the Maybury Sanatorium indicate that prompt and continued hospitalization is helpful in returning such children to normal health.

In any large community, especially an urban community, there are, all told, a considerable number of children in whom tuberculosis produces definite pulmonary lesions. The larger number of these are Primary Type, but a considerable sprinkling of Reinfection Type occurs. Some of these have lesions that are very extensive. The data presented in this study indicate that the children of the group, who were kept in the hospital until the disease was under quite satisfactory control, fared better than those who left the hospital before their disease could be so classified. The over-all picture appears to indicate that hospitalization is decidedly beneficial.

Follow-up extended over a considerable time, the shortest being six months, the longest seventeen years. Among the 153 Primary cases which were followed after discharge, 142 were regarded as clinically well, one had been readmitted to the hospital and 10 had died.

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* From Detroit and the William H. Maybury Sanatorium (Detroit Tuberculosis Sanatorium), Northville, Mich.

Synopsis of paper read before the California Trudeau Society, Los Angeles, March 30, 1944.

Let us see to it that our lives, like jewels of great price, be noteworthy, not because of their width, but because of their weight.

—Seneca, *Epistula ad Lucilium.* Epis, xciii, 4.

TUBERCULOSIS IN LOS ANGELES*

A JOINT HEALTH DEPARTMENT AND TUBERCULOSIS ASSOCIATION STUDY IN ORGANIZING FACTS FOR PROGRAM PLANNING

NORMAN B. NELSON, M. D., DR. P.H.
AND
HERBERT I. SAUER
Los Angeles

THE Los Angeles City Health Department and the Los Angeles Tuberculosis and Health Association have for some time been studying the tuberculosis problem, as it exists in our city, with a view to a better use of available facilities. We have just completed, for example, a study of tuberculosis in Los Angeles for the years 1942 and 1943, with special reference to answering the questions (1) Where is our tuberculosis problem? (2) Who is finding tuberculosis and who is failing to find it?; and (3) In what groups do we need to intensify our tuberculosis program?

I. WHERE IS OUR TUBERCULOSIS PROBLEM?

Tuberculosis still exists in all parts of the city. The rates are the lowest in West Los Angeles, Eagle Rock, Highland Park, the Wilshire area, and the Southwest or Adams section of the city. In these areas there is reported an average of approximately 70 tuberculosis cases per 100,000 population.

Other areas with moderate rates, of less than 100 cases per 100,000 population, are Hollywood, San Pedro-Wilmington and San Fernando Valley.

The Southeast area has a high rate, approximately 160 cases per 100,000 population. The highest rates, 250 per 100,000, are reported for the Central and East areas. There are many cheap rooming houses in these areas, as well as much overcrowded substandard housing.

In the Central area the majority of cases (71 per cent) occur in the white population. In the East area, the Mexican problem is introduced. Thirty-seven per cent of the cases here occur among Mexicans and only 34 per cent occur in the white population. The Southeast area includes the Negro section of the city, and 45 per cent of the cases in this area occur among Negroes. The only other areas in which race must be considered is the San Pedro and Wilmington area, where 26 per cent of the cases have occurred among Mexicans.

It is realized that housing, sanitation, and susceptibility are important factors in the spread of disease among the Negroes and Mexicans. We feel, however, that these groups deserve special attention, and special study by individuals who understand their special problems.

II. WHO IS FINDING TUBERCULOSIS AND WHO IS FAILING TO FIND IT?

Only 24 per cent of cases coming to the attention of the Los Angeles City Health Department are reported by private physicians. It is interesting to note the relative number of cases reported by doctors of medicine, doctors of osteopathy, and doctors of chiropractics. Approximately 16 cases per 100 medical doctors per year are reported to Los Angeles City Health Department; only 7 cases per 100 per year were reported by osteopaths; and 2 cases per 100 by chiropractors.

Eighteen per cent of Los Angeles tuberculosis is reported first by the Los Angeles County General Hospital. In a great many of these cases the diagnosis has been made before the patient is sent to the hospital.

Twenty-six per cent of the cases are reported for the first time by the Los Angeles City Health Department. These cases were referred to the health department for examination by various sources. In spite of the fact that tuberculosis is required by State law to be reported by physicians on the original report forms, in 1942-43 more than one-eighth of the resident cases were reported by death certificates only. The balance of the cases were reported by the tuberculosis association clinic, school clinic, and other clinics and sanatoria. For Los Angeles City last year, only 16.8 per cent of the cases were discovered in the minimal stage. Private physicians reported a bare fraction above twenty per cent as minimal.

III. IN WHAT GROUPS DO WE NEED TO INTENSIFY OUR TUBERCULOSIS CONTROL EFFORTS?

Tuberculosis in adolescents and young adults is often thought of as being a fairly rapid, or acute type of tuberculosis, with exudative lesions predominating. Among older people the lesions are usually considered more likely to be of a fibroid type, with low-grade activity and developing more slowly. It would thus seem that minimal tuberculosis should be discovered more easily among older people than among younger people. This may be true, but the fact remains: In Los Angeles at least, minimal active tuberculosis is often reported among young people, but it is rarely reported among older people.

The available clinical evidence indicates that tuberculosis progresses more rapidly among Negroes than among whites. Thus it would seem reasonable that tuberculosis should be more frequently reported prior to death in whites than in Negroes. Just the opposite, however, was found to be true. Only 27 per cent of the Negro tuberculosis deaths were unreported at death in 1943, whereas 48 per cent of the white deaths were not reported.

It would seem from these figures that our efforts in locating tuberculosis in young people and non-whites have yielded results. It follows then that, while our efforts must not be discontinued in these two groups, they must be extended to the older age groups, especially in the white population.

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* From the Los Angeles City Health Department and the Los Angeles County Tuberculosis and Health Association.

Read before the California Tuberculosis and Health Association, Los Angeles, March 30, 1944.

Of all tuberculosis deaths in Los Angeles City, approximately 40 per cent had never been reported as cases to the City of Los Angeles, insofar as could be determined from a search of the files.

SUMMARY

To review the facts on Los Angeles, different areas of the city vary in incidence from 50 to 250 cases per 100,000 population. Forty per cent of Los Angeles tuberculosis deaths are never reported as cases. Only 27 per cent of Negro tuberculosis deaths in 1943 were not reported as cases prior to death, whereas 48 per cent of white deaths were not reported. Only 20 per cent of tuberculosis cases are reported by private physicians. Only 16.8 per cent of cases were discovered in the minimal stage. M. D.'s reported 16 cases per 100 physicians per year; osteopaths 7 per 100 per year; chiropractors 2 per 100 per year. More than twice as many older adults were not reported prior to death, as young adults.

1734 North Fuller Street.

PROBLEM OF TUBERCULOSIS IN CALIFORNIA STATE HOSPITALS*

EDWARD KUPKA, M. D.
Los Angeles

THE problem of tuberculosis in hospitals for the insane and for the mentally deficient has long been recognized. Year after year, mortality statistics demonstrate that death rates within such institutions are many times as high as in the general population. In the United States about 5 per cent of all tuberculosis deaths occur in mental hospitals.

The California Health and Safety Code recognizes the problem by listing specifically amongst the functions of the Bureau of Tuberculosis the advising of officers of State institutions regarding the proper care of tuberculous inmates. In the 10 California mental hospitals, the statistics in regard to tuberculosis deaths speak for themselves. One hundred sixty-three patients died there of tuberculosis during the fiscal year 1942-43, out of an inmate population of 28,258 (as of June 30, 1942), giving a rate of 577, in contrast to the California rate of 50.9 for the year 1942. For the two types of institutions, the rate is 609 for the mental hospitals and 409 for the mentally deficient hospitals. The true rates are higher than these, since some of the patients, especially in the more deteriorated categories, die of tuberculosis without diagnosis.

CONTROL PROGRAM STARTED 13 YEARS AGO

The first beginnings of a modern control program were made by Dr. Fred O. Butler at the Sonoma State Home 13 years ago. X-ray films of each new admission, supplemented by segregation of infectious patients in separate buildings, were the pillars of his program. In 1939 two of the hospitals, Napa and Patton, were designated as central depots for the patients, whither diagnosed cases were to be sent from the institutions of the north and south respectively. Plans for new buildings for the tuberculous were drawn up, and the buildings at Patton were completed and have been used for this purpose for some time. Construction at Napa was delayed by the war, and when the building was completed, it was turned over for the duration to the Navy for psychiatric patients. The tuberculosis patients there remain in the old isolation wards. At Napa, Patton, and Sonoma at present there are 600 patients in buildings specially for tuberculosis, a total greater than the capacity of any tuberculosis sanatorium in California except Olive View.

The most extensive survey in State hospitals has been done in New York by the combined efforts of the New York State Department of Mental Hygiene and the New York State Department of Health, under the leadership of Dr. Robert E. Plunkett. In a preliminary study at the Newark State School for Mental Defectives, made in 1936, Dr. Plunkett found that 90 per cent of the patients over the age of 30 were positive to tuberculin. At that institution, with few discharges and close contact between patients, it was demonstrated that every case of reinfection-type tuberculosis, which developed during residence in the institution, could be associated with the presence of another infectious case in its immediate environment. On the other hand, among inmates who at no time were associated intramurally and intimately with a patient with open tuberculosis, not one case of reinfection type tuberculosis developed.

INTRAMURAL SPREAD OF TUBERCULOSIS

In 1938 it was discovered that, of all the patients on the tuberculosis register of Seneca County, New York, 23 per cent were or had been employed at the Willard State Hospital, which was located in the county, and that, in the preceding twenty-four months, 11 new cases of active tuberculosis had been reported amongst employees of that institution. This led to a thorough survey at Willard, which showed that of 3,407 patients, 76 (2.2 per cent) had active tuberculosis, 157 (4.6 per cent) had probably inactive reinfection tuberculosis, and 100 (3.2 per cent) had healed reinfection tuberculosis, or a total of 10 per cent had x-ray evidence of present or past adult type tuberculosis. In addition to this, 10.3 per cent had calcifications. Yet among 587 admitted in the year of the survey, only 3 per cent had reinfection tuberculosis. This demonstrated the tremendous rate of intramural spread of the disease. Two years later, all the patients were rerayed, and only 16 (0.7 of 1 per cent) were found to have acquired new infection.

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* From the Bureau of Tuberculosis, California State Department of Health.

Read before the California Tuberculosis and Health Association and the California Trudeau Society in a symposium on Tuberculosis in Institutions in California, Los Angeles, March 29, 1944.

The experience at Willard led to a statewide plan involving all 26 of the institutions. The New York Legislature appropriated $45,000, which provided for two 4x5 mobile units, 50,000 4x5 films, additional 14x17 films, chemicals, two x-ray technicians, and three physicians. In July, 1941, work was begun with the following objectives:

a. X-ray of all inmates.

b. X-ray of old employees, and aid in their hospitalization if found tuberculous.

c. X-ray of new admissions.

d. X-ray of new employees (preëmployment).

e. Reray of employees on tuberculosis wards every three months, and of all other employees giving direct service to any patients every six months.

f. Close consultation between Department of Institutions and Department of Health.

g. Reëxamination of all inmates by x-ray after one year.

h. Adequate system of records.

i. Educational and prophylactic measures amongst employees.

TWENTY-THREE INSTITUTIONS STUDIED

This program was continued after the first year by further appropriations. Although the war made it impossible to obtain enough personnel to carry out all of the provisions of this plan, Dr. Plunkett was able to report that, in the first two years of the survey, 23 of the 26 institutions had been studied. Sixty-eight thousand, seven hundred forty-three patients had been x-rayed, and of these 4.7 per cent, or 3,220, had significant tuberculosis, while 4.6 per cent, or 3,151, had healed reinfection tuberculosis. Of the men 5.3 per cent, and of the women, 4.1 per cent had active infection. The highest rate in any institution as a whole was 8 per cent patients with active tuberculosis.

In the 14,228 employees examined during the same time, 151 (1.1 per cent) had significant tuberculosis, while 359 (2.5 per cent) had healed reinfection tuberculosis, giving a total percentage of 3.6 with evidence of reinfection disease.

In the fall of 1942, the Bureau of Tuberculosis began a study of tuberculosis control in the State hospitals of California. Each institution was visited, and it became evident that wide differences existed. Only one institution (Sonoma) did routine x-ray examination of patients (and upon admission only), and had a pneumothorax clinic. At another (Camarillo), a staff physician, with training in tuberculosis, had recently begun a program of fluoroscoping the resident patient population. At Patton a physician patient awaiting discharge was studying the known tuberculous from the standpoint of therapy. (The Langley Porter Clinic, which opened subsequently, has from the start taken standard x-ray films on all new admissions.) At the other institutions, there was no formal case-finding program. When tuberculosis was discovered by clinical methods alone, it was commonly far advanced, and partial isolation was instituted until the patient could be transferred to Sonoma, Napa, or Patton.

TWO THOUSAND EXAMINATIONS GIVEN

However, each institution had standard x-ray equipment. In order to make a start, even though at the time x-ray film was difficult to obtain, the Bureau suggested that x-ray films be taken on all employees, and undertook to read the films. A schedule of fluoroscopic examination of patients on the most deteriorated wards was begun at Patton, Norwalk, and Pacific Colony, and up to the first of July, 1943, over 2,000 such examinations and film interpretations were made by the Bureau, while Dr. Baker expanded his survey at Camarillo.

Patton State Hospital, with 250 segregated tuberculosis patients, had no staff physician with training in tuberculosis, and Dr. Webster, the Superintendent, created a position for a tuberculosis physician, which was filled on July 1, 1943, by Dr. R. E. Smith. In addition to giving supervision to the resident tuberculous, Dr. Smith speeded up the survey program at three institutions, visiting Norwalk and Pacific Colony at frequent intervals. As of the present time, almost 10,000 examinations have been made in the four southern institutions. Among these were all the employees. From 15 per cent to 20 per cent of the fluoroscoped patients have had films also. We are not satisfied with the fluoroscope, but are using it until additional equipment and personnel have been obtained.

Of the patients hitherto unsuspected of harboring infection, from 4 per cent to 5 per cent were shown to have active pulmonary tuberculosis. The highest percentages were found on the most deteriorated wards and among patients committed for chronic alcoholism.

MOBILE UNIT PURCHASE PLANNED

Until adequate segregation is provided for every tuberculosis patient discovered in the institutions, and until we have discovered each such patient, the tuberculosis rate will continue to be high for reasons inherent in the high initial infection rate, the type of patient, and the crowded wards. In addition to the 600 previously-diagnosed tuberculous in the institutions, we have discovered between 200 and 300 patients with active disease. On the basis of 5 per cent of the unsurveyed patient population, there remain still 1,000 undiagnosed tuberculous. Among the 10,000 patients admitted annually to all the institution, 150 come in with infection. For every one who enters with tuberculosis, two more have been acquiring it during their commitment.

The Department of Institutions plans to meet this problem by the purchase of one 4x5 mobile x-ray unit, with employment of adequate personnel for its operation and the processing of the films. This truck will move from institution to institution and take films of the entire patient and employee population at each. To make possible the segregation of the tuberculous who are being found and who will be found, the post-war building plans of the Department of Institutions call for four new tuberculosis buildings; additions to the units at Napa and Patton, and new units at Sonoma and Pacific Colony. These buildings will aggregate enough beds to segregate all the patients whom we expect to find, but they will be so constructed that they can be converted, ward by ward, for the use of patients who have no tuberculosis. This is a wise provision, because, once the initial survey and segregation have been accomplished, the number of beds necessary for tuberculosis will rapidly decrease. Intramural infection will become uncommon. When buildings are ready for occupancy, additional physicians with training in tuberculosis will be engaged, and these specialists, in addition to their clinical tasks, will play a major rôle in the survey activities.

It is impossible to avoid the conclusion that the undiscovered tuberculosis in our mental hospitals is one of the most concentrated and dangerous reservoirs of infection in the State. By means of discharged and paroled patients, it seeps continuously into the general community. The Bureau of Tuberculosis feels that its contribution to the control of this menace is one of the most rewarding activities in which it is currently engaged.

217 West First Street.

TUBERCULOSIS IN SONOMA STATE HOME*

F. O. Butler, M. D.
Eldridge

THE Sonoma State Home was opened on its present site in November, 1891, with a population of 150.

The first unit for tuberculous patients was built with a capacity of 42 in 1912, when we had a population of approximately 1,000. Additional units have been added since, so that now we have patients in four different buildings for both sexes, with a bed capacity of 121, with extensive overcrowding.

The total population in the Institution on March 1 of this year was 4,186 with 3,286 actually in residence, the remainder being on parole and escape. The total number admitted, since the opening in 1891 to March 1, 1944, was 12,093.

The average age on admission is approximately 17 years and the average age at death of all cases approximately 27 years, or a life span of ten years as against the average for normal individuals, as you know, around 63 years. We feel this short life span is due to the physical and mental condition of the majority of patients received. This particular type of low-grade patient is undoubtedly a factor for the increased percentage of the tuberculous over that of normal individuals. Also, there is more overcrowding in our low-grade cottages.

PRESENT X-RAY POLICY STARTED IN 1934

It has always been the policy of the Institution to segregate and treat active communicable pulmonary tuberculosis. However, it was not until 1934 that we arranged a definite system of tuberculin testing all patients and x-raying all positive reactors. This survey has continued to the present time. During this period of 10 years, 6,485 patients have been examined, 500, or 7.7 per cent of which have been diagnosed as having tuberculosis. They were classified as follows: 186 minimal, 157 moderately advanced, 41 advanced, 19 miliary, 40 childhood, 44 arrested, 1 tubercular spine, 7 unclassified. Of these 500, 67 per cent were idiots and imbeciles, and the other 33 per cent morons and borderlines, thus bearing out that tuberculosis does predominate in the lower group mentally and physically, and where overcrowding is most prevalent. Some 145, or 16 per cent of our deaths in the institution, are due to tuberculosis, their average at death being 23 years. Average age at time of diagnosis is 24 years.

In July, 1941, because tuberculosis occasionally occurred in a "negative tuberculin" patient, it seemed wise to have at least one x-ray on record of every patient in the institution. Therefore, it has developed that we x-ray, tuberculin test and obtain a clinical record of every new patient in the institution, and we have extended the x-ray survey to include all old patients, until by now nearly all have been either x-rayed or fluoroscoped. All negative tuberculins are repeated in one year. All patients going out on parole are x-rayed unless they have been examined in recent months.

FLUOROSCOPIES EVERY SIX MONTHS

In the past year, because of the shortage of film and storage space, an extensive fluoroscopic program has been instituted, with the goal that almost every patient in the institution be fluoroscoped every six months and x-rayed at the time of fluoroscopy, if indicated. The interval of six months was chosen because there had been several instances where apparently negative chests had been found to have developed communicable tuberculosis within a year following examination. The elderly and extremely crippled patients are gradually being deleted as soon as their chests are determined to be negative for tuberculosis. They are to be checked when indicated.

All new employees are tuberculin tested and x-rayed. All employees with tuberculosis are referred to their family physician for care and treatment. Arrested cases are checked in the institution twice yearly. Some survey work has been done among employees, especially in wards or cottages where tuberculous patients have been found. So far, this has resulted in the finding of one employee with active tuberculosis, which we felt was a result of contact in the institution. We hope to extend this survey so that each employee has at least one x-ray for record and subsequent fluoroscopic examination yearly. In the meanwhile they may voluntarily come for this examination. Also all employees on the wards and cottages are to have a tuberculin test once yearly until the test becomes positive. All tuberculosis hospital nurses are x-rayed twice yearly, and it has been recommended that a tuberculin be done every six months until positive.

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* From the Sonoma State Home, Eldridge, California. Read before the California Tuberculosis and Health Association and the California Trudeau Society in a symposium on Tuberculosis in Institutions in California, Los Angeles, March 29, 1944.

NO DECLINE IN NUMBER OF DIAGNOSES

During the past ten years the number of diagnoses made has not appreciably declined. There are probably several explanations for this: (1) It has taken us a number of years to get through the institution on survey because of lack of personnel. (2) Development of contact cases, due in part at least to overcrowding. (3) Lack of frequency of review. In the next several years we anticipate a decline. However, there are a number under observation for diagnosis at present, and there will be some who will develop tuberculosis from previous contacts. Some will be admitted from the outside. The death rate remains fairly constant.

In the past ten years approximately 35 cases have been admitted here who were diagnosed prior to admission, and since we have been x-raying all new admissions we have diagnosed a number who had no previous record of tuberculosis.

Treatment consists of bed rest and general care, collapse therapy, pneumothorax, phrenemphraxis, etc., as indicated. Since about 1940 or 1941, 122 patients have been treated with pneumothorax. Of this number 27 are now arrested, 38 are on active treatment with adequate collapse, 21 were abandoned because collapse therapy was unsuccessful or inadequate, seven abandoned because of uncoöperativeness of the patient, 17 died from tuberculosis, two died from other causes, five were transferred or escaped, and five on parole, either arrested or maintaining adequate collapse. Fifteen phrenemphraxis, 23 pneumonolyses and one thoracoplasty have been done. Fifty-eight per cent of those under pneumothorax treatment fell in the idiot and imbecile classification.

POST-WAR PLANS DEVELOPED

For the furtherance of work in tuberculosis in the Sonoma State Home we now have post-war plans fairly well developed for the construction of a new tuberculosis hospital with a bed capacity of approximately 200, with a rounded out personnel to properly operate such a building in every detail. Our hope in time is to be able to make a better showing than we have been able to do in our old and overcrowded, inadequate buildings, which were really condemned many years ago, but for which we have been unable to secure money sufficient to build the modern type construction. This building is at the head of the list of our post-war building program at Sonoma in the amount of over seven million dollars. Plans are that immediately the war is over we will begin construction, the hope being that in time tuberculosis can be so controlled that the building can gradually be turned over for other uses in the institution.

Sonoma State Home.

EXPERIENCES AT PATTON STATE HOSPITAL*

R. E. Smith, M. D.
Patton

TUBERCULOSIS has long been recognized as a problem by the authorities of the State Hospitals of California. In the late twenties, Patton State Hospital was selected as the place for hospitalization of known tuberculous patients from other mental institutions of the State. Cubicles built into two of the wards were the only provision made for these patients, at first. Seven years ago two new buildings were put up for the housing of tuberculous patients. These each had a bed capacity of 45 to 50. These wards or cottages were increased in size, two years ago, so that now there are beds for 135 male and 135 female tuberculous patients. Emphasis has always been upon segregation. Rest, nourishment and collapse therapy, by artificial pneumothorax and by pneumoperitoneum, are the principal means of treatment used thus far.

Some indication of the seriousness of the problem presented by tuberculosis is given by the annual death rate due to the disease. For the fiscal year ending June 30, 1943, the total number of deaths at Patton State Hospital was 297. Tuberculosis was given as the cause of death in 61 or 20.5 per cent of these cases.

The patients already segregated in the tuberculosis wards were studied carefully and reclassified from the standpoint of present status and exact diagnosis.

Table 1

Female Patients 135		
Found to be arrested or non-tuberculous	42	31.1%
Minimal active	33	24.4%
Moderately advanced	32	23.7%
Far advanced	28	20.7%

Table 2

Male Patients 113		
Now arrested or non-tuberculous	24	21.2%
Minimal	27	23.9%
Moderately advanced	33	29.2%
Far advanced	29	25.6%

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* From the Patton State Hospital, Patton.
Synopsis of a paper read before the California Tuberculosis and Health Association and the California Trudeau Society in a symposium on Tuberculosis in Institutions in California, Los Angeles, March 29, 1944.

The tuberculous found in a partial fluoroscopic survey among the apparently healthy patients subsequent to the above analysis were divided as follows:

TABLE 3

Female Patients	30	
Minimal	7	23.3%
Moderately advanced	13	43.3%
Far advanced	5	16.6%
Observation cases (later found negative)	5	16.6%

TABLE 4

Male Patients	48	
Minimal	11	22.9%
Moderately advanced	9	18.8%
Far advanced	21	43.8%
Observation cases (later proved negative)	7	14.6%

Thus 66 patients of 1,008 were found with active disease or over 6 per cent.

CONCLUSIONS

1. Tuberculosis continues to be a major problem in state hospitals.

2. A survey should be made of all the inmates of each state hospital to determine who have tuberculosis.

3. All patients having pulmonary tuberculosis should be segregated.

Patton State Hospital.

FUTURE PLANS OF THE DEPARTMENT OF INSTITUTIONS*

DORA SHAW HEFFNER
Los Angeles

AFTER visiting the ten State institutions which handle approximately 30,000 mentally ill and mentally defective, conferring with superintendents and physicians in the institutions and with officials of the Department of Health, I reached three conclusions in favor of an intensive tuberculosis program in these institutions. They are:

1. That the tuberculous within the institutions will be approximately one-tenth of the total undiscovered tuberculous in the state. They are under custodial control, easy to reach, and need not be sent to a hospital if discovered tuberculous since they are already in one. By obliterating the problem within the institutions, the total California tuberculosis problem could be lessened by 10 per cent.

2. Thousands of employees within the Department of Institutions are exposed to tuberculosis, and not only constitute a personal and public health problem if they acquire the disease. but a very great expenditure and natural burden for the State through industrial compensation.

3. Since, under the present parole plan of the Department of Institutions, a large percentage of patients, either for transient period or permanently, are sent out of the institutions, these persons, if infected, constitute a menace to the family and to the general public.

Those three statements I presented to the Governor and the Governor's Council. They understood that a step should be taken, even before the war is over, for the protection of the people, both in the institutions and in the State.

In October we presented to the Governor's Council a plan for the establishment of two mobile units, completely staffed, to go to the various institutions, both in the north and in the south, to take x-rays of every person admitted, x-rays of every new employee, and x-rays of the entire present employee and patient populations, these x-rays to be repeated at frequent intervals. You can see, with approximately 30,000 patients and 4,000 employees, how important it will be for us to have a sufficient number of tuberculosis specialists, technical and office assistants, and adequate equipment. I have been given a report that the initial cost for those two mobile x-ray units, completely staffed, will be about $60.540.

At present we have in all of our institutions 567 beds set aside for tuberculous patients. If we work out the post-war building plan I hope for, and which has been approved, we shall be able to take care of 1,394 tuberculous patients. We shall have four institutions caring for tuberculous patients, two in the north and two in the south, one in each section for mentally ill and one for mentally defective. These units, which will provide for the isolation of tuberculous patients from the others, will be located at Napa State Hospital, Patton State Hospital, Sonoma State Home, and Pacific Colony, and will be constructed at a cost of approximately two million dollars.

PRACTICAL INTERPRETATION OF NUTRITION IN WAR TIME*

GRACE G. HARDGROVE
Los Angeles

THROUGH Child Hygiene and Pre-Natal Conferences, the visiting nurses in homes and in industrial plants, and in collaboration with the nutrition committees of the War Councils, Home Economists in schools, industry, public utilities, and other agencies, nutrition information is adapted to meet the needs and the interests of the various groups.

What are the problems, and how are we meeting them?

1. Influx of population, untrained in public health.

Women from migrant families who have babies, or who are pregnant, usually come to the

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* From the California State Department of Institutions. Read before the California Tuberculosis and Health Association and the California Trudeau Society in a symposium on Tuberculosis in Institutions in California, Los Angeles, March 29, 1944.

* From the Nutrition Division, Los Angeles City Health Department.
Read before the California Trudeau Society and the California Tuberculosis and Health Association, Los Angeles, March 30, 1944.

Child Hygiene or Pre-Natal Conference. On the first visit, the mother is given individual instruction on family diet, or fundamental pre-natal diet. Pleased with this friendly contact, she returns each month for new teaching on seasonal foods, their care, preparation, and use.

2. Influx of racial groups with dietary habits peculiar to them.

Using nutritionally desirable foods peculiar to a racial group, we teach improved methods of preparation to retain food values, plus the addition of locally available foods to make a more adequate diet. All possible methods are being used to introduce good habits in nutrition to racial groups, especially Mexicans and Negroes.

3. Shopping difficulties, with pressure of time and rationing.

Mothers, formerly full-time in the home, could use plentiful, inexpensive foods requiring a long time to prepare, but must now get dinner in 30 minutes. Advance menu planning and shopping, use of prepared foods, shortcuts, omission of nonessentials, and distribution of work among members of family, are emphasized in every way possible.

4. Unpredictable surpluses that flood the market or tax storage facilities.

Reminders are issued to use seasonal surpluses, and new methods of preparation are taught to relieve monotony.

5. Wives of service men living alone, in small rooms, or hotels, have irregular and inadequate diets.

Attention is given individual's problem. For those who eat out, suggestions are made on choices in restaurants to secure better diet, and on selection of extra foods, such as orange, tomato, carrot, pint of milk, etc., that may be eaten in the room.

6. Point of interest has changed.

PRICES NO LONGER DETERMINE DIET

Economy no longer appeals to a family who have five pay checks instead of one. We find strawberries at 50c a basket being used by large families who may have no milk or vegetables in the day's diet. Greater means doesn't always provide better nutrition, but more often indulgence in luxuries. The need for education is reëmphasized. To which appeal are they receptive? Is it health, beauty, pride, fear of consequences? Methods employed by advertiser and merchandiser may give us clues.

On the other hand, stationary incomes are causing severe nutritional problems in families that formerly ate adequately, but now need help in wise choice of foods for rounded diet.

7. Failure of some members of allied professional workers to realize that they should bring their nutrition information up-to-date, and make it a part of their daily practice and teaching.

In some instances it is necessary to awaken professional workers to the great contribution good nutrition may make to their well-being and teaching. A simplified evaluation of their diets reveals deficiencies they did not realize existed, and increases their interest in new interpretative material they may use. Current information on seasonal foods is brought to them, for example: when oranges are scarce, new green cabbage at 5c per pound offers a more efficient source of Vitamin C than tomatoes at 25c per pound. With an exhibit of actual foods that form the foundation of a daily diet before them, they realize that unless one has a good breakfast that includes cereal, milk, and fruit, eats at least one vegetable at lunch, and drinks milk at a second meal, all of the dietary essentials are not included in the individual's diet.

PROJECTS FOR PROFESSIONAL GROUPS

Projects started that require coöperation of professional groups:

(1) A simple presentation of the fundamental diet, using nutritionally desirable foods enjoyed by Mexicans, plus those needed to make an adequate diet is being developed. This will be pictorial in nature, with interpretative Spanish idioms used correctly.

(2) A laboratory class in simple food preparation for expectant mothers, including interpretation of a normal, prenatal diet; a good diet for the family, with emphasis on adapting family diet to the growing child, is being arranged. This will be given in adult education in strategic areas. It will cover subject matter the physician and nutritionist consider desirable. It should reach the wives of service men awaiting the birth of their babies, and should include the private patients who have had no opportunity to cook or plan for family feeding.

This class will be valuable in the nutritional training given mothers at the opportune time, when it benefits both mother and baby. It will supplement the individual instruction which the very busy physician has given the mother. It will be effective only if the physician requires the mother to attend, as a part of her prenatal preparation, for her own well-being and the good health of her future family.

Let us all apply the principles of good nutrition in our daily living, if we expect to maintain leadership in public health teaching.

NECESSARY OFFICIAL MACHINERY FOR THE CONTROL OF TUBERCULOSIS*

L. L. Lumsden, M. D.
New Orleans, Louisiana

It was pointed out that the legal responsibility for the control of tuberculosis, a communicable disease, is upon the official health authority. The growth of full-time county health units during the past three decades was outlined. It was pointed out that a well-organized, full-time local

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* Synopsis of a paper read before the California Tuberculosis and Health Association, Los Angeles, March 29, 1944.

(county or city) health department, adequately staffed with trained personnel, should be the most important agency in the control of tuberculosis.

LET'S DELIVER*

Glenn V. Armstrong
Los Angeles

THERE is not known today any pill, powder or potion which will cure tuberculosis. Yet tuberculosis could be controlled in the matter of a few years if—and there is where health education comes in—if the facts we now know about the disease were known to and used by all.

Roughly there are two groups to whom these facts must be given, and given in a manner that will prompt those people to act both as individuals and as a group, upon those facts.

These two groups are: first, the sick; and second, the well. The sick must know the facts about tuberculosis and must act on those facts in order that they do not spread their disease in themselves and among others. The well must know the facts about tuberculosis, and must act on those facts in order that they do not become sick. How do we reach these groups?

The sick person who has not been examined is, as far as the health educator knows, well. We do not know he is sick, although he himself may suspect that he is. But the sick person we know to be sick can be reached through the physician, the nurse, the sanatorium employee. Note that I said employee, because, properly guided by competent medical advice, the lay worker in the sanatorium, hospital, or health agency can oftentimes "get to" the patient when the professional worker cannot.

ASSISTANCE TO OTHER WORKERS

It transpires that we in tuberculosis associations should be seeing to it that both the professional and the lay worker in our agency, and in the health department and the hospital and sanatorium, have the materials and the methods to get the facts across to the patient, and through him to his family and friends who visit him.

The well person, other than the patient's family, is harder to reach. Dr. G. Lynde Gately once said that "time and effort would be wasted in urging the people of a section to solve a problem that is nonexistent in that section." We don't have to worry about tuberculosis being nonexistent in the area served by any one of our California associations. It's there, all right! True, certain areas may have more or less tuberculosis than others.

Here is a good place to point out that health education is not something apart from other phases of an Association's program. A tuberculosis Association's major function is health education. Health education is part and parcel of all the Association's activities, from answering the telephone to writing to the President of the United States.

Statistics, which reveal which of the areas have the most tuberculosis, are part of health education. These figures are the ones we take to the leaders in that portion of the city or county to arouse their interest in the setting up of a health-education program.

We show those leaders the necessity for telling the people in that area that tuberculosis is a threat to them and their loved ones.

These leaders may be individuals or they may be groups. Here again a little research will get us started in the right path. A little reading of the local newspaper; a little listening in social gatherings and a little observation will reveal which individuals, and which clubs and lodges and churches, are the ones who get things done in the community.

The use of others is sometimes hard to learn, but they must be used because you cannot do the job alone, and because of a good health-education program must be based on community participation.

PUBLIC AGENCIES AND HEALTH EDUCATORS

That community participation does not exclude the public agency. There seems to be some resistance in some parts of the State to the idea of a public agency having a health educator on the staff. Yet health education is a part of the public agency job just as much as immunization or rat-proofing. The late Dr. Horton Casparis once said, in discussing the tuberculin testing of small children, "When you stick baby, you stick the whole family." The whole family will remember why something is being done if the reasons are given at the time. Health departments hire people to teach the community how to rat-proof buildings; why not, then, hire someone to teach the public to "tuberculosis-proof" or "dipththeria-proof" or "rickets-proof" a child?

However, the health educator must not be a "publicity man" for the health officer. He or she must be a "publicity man" for health, and he will use the medical profession, the nurses, the dentists, the clergymen just as the voluntary agency does. He will use the Boy Scouts and the Camp Fire Girls and the Epworth League, the Baptist Young People's Union and the Catholic Youth Organization to spread the facts the health department has, which will prevent disease, lower the death rate and increase the physical and mental vigor of the people it serves.

Fatigue spans the arch between health and disease. We know that artificially exhausted animals are more susceptible to pneumonia—that tuberculosis is in part a fatigue problem.—M. Z. Gross, *Hygeia,* October, 1942. —*Tuberculosis Clip Sheet,* July, 1944.

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* From the Los Angeles County Tuberculosis and Health Association.
Synopsis of a paper read before the California Trudeau Society and the California Tuberculosis and Health Association, Los Angeles, March 30, 1944.

NEGROES IN CALIFORNIA*

Floyd C. Covington
Los Angeles

THE American Negro constitutes a very virile segment of the war-motivated mass migration. The 1930 census showed that Los Angeles City had a Negro population of 38,894; the 1940 census, 63,774. In 1942 a traction company, needing replacements in its section hand gangs, imported 3,100 Negroes in two months. This was the beginning of the great push. The crying need for manpower in the Pacific Coast region, and the President's Executive Order 8802 eliminating racial discrimination in war industries for the duration of the war, stimulated mass migration of the Negro at an excessive rate, not only to Los Angeles, but to the Bay Area.

The most serious problem at present facing all newcomers is the critical housing shortage. The Negro, of course, faces an even greater plight in this respect. Racial restriction covenants, written in or implied, force him to live in a comparatively small area which has been, and is even now more rapidly becoming, a blighted zone. On every hand over-crowding and congestion is becoming the rule rather than the exception. The usual mal-social factors of over-crowding, delinquency, disease, and group exploitation have come to California, too, as the hand-maidens of mass migration.

From the extreme repression to a newly-found chance for expression will be the attitude with which our schools will have to deal. Teachers will find it necessary, while endeavoring to teach the English language, to know and understand the "jive slanguage" and the reasons for it. Many of the children of our Negro newcomers have little or no formal education. They are over-age and under-educated. Attendance officers are more than busy in trying to "catch-up" with these newly arrived children. They are on the streets, rapidly becoming a part of the new crop of "delinquents," because they are totally unaware of a compulsory school law.

THREE "S'S" MUST SUPPLEMENT THREE "R'S"

Booker T. Washington has left for us a descriptive dictum symbolizing the condition with which schools of California must gear their educational sights: "You can't keep a man in a ditch unless you stay there with him!" Thus, the disadvantages and restrictions of our backward communities have been transplanted into our more favorable regions. What the results will be will depend upon the sympathies, understanding, and techniques of our greatly strained educational system. Our analysis of these conditions must enable us to differentiate between effects of previous bad environments and innate racial characteristics. More rigid and severe discipline, and "welfare" schooling with the emphasis on punishment, will not be the balm to heal the attitudinal hurts of these confused and frustrated children who are already running away from the four fears. In our effort to teach the standard three "R's," we must apply the three "S's": *Sympathy, Sense of Humor, and Sincerity.*

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* From the Los Angeles Urban League, Los Angeles.
Synopsis of a paper read before the California Tuberculosis and Health Association in a symposium on Tuberculosis in Minority Groups, Los Angeles, March 29, 1944.

EAST AREA HEALTH PROGRAM OF LOS ANGELES*

Theresa V. Dixon, P.H.N.
Los Angeles

THE East Area Health program of Los Angeles is a tuberculosis case-finding program for both tuberculosis suspects and the apparently healthy in the Negro population. In 1939, the Los Angeles Tuberculosis and Health Association set aside one-tenth of its income to extend diagnostic facilities combined with emphasis on health education, where the need was greatest. The area served has a population of more than 50,000.

Our objectives were to detect as many cases of tuberculosis as possible in the area and to assist in getting them under treatment; to teach health, with particular emphasis on tuberculosis, to both physicians and layman; by means of physical examinations to uncover other diseases and thereby improve the health of the community; to increase our knowledge of the racial characteristics in tuberculosis; to assist in the control of syphilis by providing Wassermann tests, and to establish a feeling of goodwill in the community toward the Tuberculosis Association.

To carry on the work the facilities of an existing health clinic near the area were obtained. The center serves individuals with small incomes, and is held in high esteem in the community.

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* From the Los Angeles County Tuberculosis and Health Association.
Synopsis of a paper read before the California Tuberculosis and Health Association in a symposium on Tuberculosis in Minority Groups, Los Angeles, March 29, 1944.

MEXICANS AND TUBERCULOSIS**

Marguerite G. Lopez
Los Angeles

TUBERCULOSIS is the leading cause of death among Mexicans in this state. According to the California State Department of Public Health, 18.5 per cent of all Mexican deaths are due to tuberculosis. But only 4.5 per cent of all the deaths for the population at large are caused by this disease. Thus, we are informed that tuberculosis causes four times as high a propor-

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** From the Los Angeles County Tuberculosis and Health Association.
Synopsis of a paper read before the California Tuberculosis and Health Association in a symposium on Tuberculosis in Minority Groups, Los Angeles, March 29, 1944.

tion of deaths among Mexicans as among the total population.

Furthermore, upon analyzing tuberculosis death-rates for the last ten years in California we find that, whereas, the rate has been declining steadily for the total population, it has not been declining appreciably for our Mexican residents. However, an interesting point is the fact that among Mexicans tuberculosis is being reported at an earlier stage on the average than in the total population. Tuberculosis seems to occur most frequently among young Mexican women. It is gratifying to note that Mexicans are known to respond favorably to sanatorium care.

Let us now examine the reasons most commonly cited for the prevalence of this disease among our Mexican population. Environmental factors, such as crowding and bad housing, inadequate nutrition, unfavorable working situations, as well as unsanitary conditions are common to this group. No one reasonably informed can deny that their general standard of living should be improved, but that is not the whole story. Education of these people is of primary importance if tuberculosis among Mexicans is to be effectively controlled.

Thus, the finger seems to point at health education as the best medium known today for the control of tuberculosis among Mexicans as well as any other race or group.

Any health education program intended to control tuberculosis among our Spanish-speaking population should take into consideration a number of very essential points.

First, the program should be practical and applicable for the people among whom it is being tried.

Secondly, it should meet individual and community needs.

Thirdly, it should be presented in accordance with the customs, habits and general way of life of Mexicans.

Fourthly, we must never forget that a positive approach rather than a negative or critical attitude of existing bad health practices, is much more effective.

Fifthly, there should be an attempt to supplement rather than to change entirely their mode of living. For instance, we already know that nutrition is one of the important factors in tuberculosis. In teaching nutrition we should try to enrich their basic diet of beans, corn tortillas and other highly nutritious Mexican foods, with the addition of fresh fruits and vegetables not commonly eaten by this group. And, finally, educational aids, such as literature, posters, exhibits, etc., should appeal to a Mexican sense of values. Too often valuable money is lost in attempting to translate material designed for an English speaking reader, when such energy and money could be put to more effective use by developing literature directly for the Mexican group.

Mere living is not a good, but living well.
—Seneca, *Epistulae ad Lucilium.* Epis. lxx, 4.

HEALTH EDUCATION MEDIA AMONG CALIFORNIA'S MEXICAN-AMERICANS*

Maurice C. Hazan
Los Angeles

PERHAPS, before I try to discuss available or potential methods of reaching the mass of Mexican-Americans with a program of health education, it would be best to definitely determine just which of these people we are interested in reaching. In California there are approximately half a million people of Mexican or Latin-American descent. It is very probable that, of that half million, 100,000 have become assimilated into the rest of the community . . . their background is Spanish-American, but their way of life is today almost entirely American.

The majority of Mexican-Americans, however, many of them native American citizens, live among us, but are not part of our community. Their way of life, their language, their customs are different.

With these the first problem is that of approach. The very evident and tangible importance of the language difficulty makes it obvious that the Mexican-American must be approached in his own language: not English, not the stilted Castilian Spanish which is almost incomprehensible to the average Latin-American, but in the Spanish they speak in Mexico and the Southwest.

Once the problem of approach is solved, we must find the media for putting over our message. These media can be broken down roughly into several distinct methods: one, the press and radio; two, films and publications; three, the schools, for children and adults alike; four, their own social and recreational organizations.

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* From the Spanish Speaking People's Section, Office of Coördinator, International American Affairs.

Synopsis of a paper read before the California Tuberculosis and Health Association in a symposium on Tuberculosis in Minority Groups, Los Angeles, March 29, 1944.

TUBERCULOSIS PROGRAMS AMONG THE MEXICANS**

N. B. Davila
Santa Ana

AN outstanding writer on health education has pointed out that the best time to teach a child is when he is curious, and the best time to teach an adult is when he becomes frightened. Perhaps this explains the difficulty in teaching the facts about tuberculosis to Latin-Americans from Mexico. They are neither curious nor frightened. With this in mind, it is easier to understand that with the Mexican certain prejudices, economic conditions or family affections are stronger motives for a course of action than the little-appreciated factors of personal well-being.

** From the Orange County Tuberculosis and Health Association, Santa Ana.

Synopsis of a paper read before the California Tuberculosis and Health Association in a symposium on Tuberculosis in Minority Groups, Los Angeles, March 29, 1944.

To awaken the people in the realization of their problem, we must first learn their customs and prejudices; then win their confidence by befriending them, and helping them in the solution of other social problems.

Because of the difficulties of language and racial idiosyncracies, I believe our programs become more effective when we send out workers for home visitations and to hospitals and clinics who are of the same racial background.

When such workers are difficult to obtain, the second choice is to win the coöperation of the racial leaders of the community, the teachers of Mexican schools and Americanization teachers.

In Orange county various methods are made to reach the 50,000 persons of Mexican birth or descent. We are publishing translations and original material on general health in the form of periodicals; we provide entertainment for patients in the county sanatorium, and help them to solve personal problems; while for arrested patients, we have started an experiment in rehabilitation.

TUBERCULOSIS AMONG CHINESE*

Rosemary T. Kobes
San Francisco

THE health program for San Francisco's Chinese is a generalized district program. It includes well-baby conferences, tuberculosis control, immunization and dental clinics. A weekly diagnostic school conference is held, and a city health department physician spends one full day a week at the Health Center, in addition to presiding at well-baby conferences. There also are a number of part-time workers at the Health Center, and four full-time nurses, two of whom are Chinese. The San Francisco Tuberculosis Association has for some years paid the salary of one of these Chinese nurses who works under the direction of the public health department.

The total attendance at the Health Center during February, 1944, was 1,414. During this month 550 tuberculous families, in some of which there were multiple cases, were carried by the Health Center. Sixty-six Chinese children are enrolled in the Hancock Health school.

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* From the San Francisco Tuberculosis Association. Synopsis of a paper read before the California Tuberculosis and Health Association in a symposium on Tuberculosis in Minority Groups, Los Angeles, March 29, 1944.

TUBERCULOSIS AMONG THE AGED**

L. L. Lumsden, M. D.
New Orleans, Louisiana

A REVIEW of mortality statistics was presented, showing that the peak of the deaths from tuberculosis had changed during recent years from ages 15 to 25 to the older age groups. It was pointed out that with an aging population, the reservoir of tuberculosis was in the older age groups, especially men, and that the emphasis in case-finding should be based on those groups.

** Synopsis of a paper read before the California Tuberculosis and Health Association in a symposium on Tuberculosis in Minority Groups, Los Angeles, March 29, 1944.

NEWS LETTER

California Tuberculosis and
Health Association
45 Second Street, San Francisco, 5 Calif.

The California Tuberculosis and Health Association prints monthly a four page "News Letter" which is sent free of charge to anyone interested. Application to be placed on the mailing list should be sent to the California Tuberculosis and Health Association, 45 Second Street, San Francisco 5, California.

The items which follow are excerpts from recent issues of the "News Letter".

California Tuberculosis Deaths Total 3,878 in 1943

Morbidity Report Shows State Has 7,879 New Known Cases of Tuberculosis

California reported 7,879 known cases of tuberculosis and 3,878 deaths by occurrence from all forms of the disease in 1943, according to morbidity and mortality statistics issued by the State Department of Public Health.

This compares to 7,619 known cases and 3,842 deaths in 1942. The death rate has not been determined, probably in the absence of reliable population figures. Using nine months mortality figures projected on the basis of a population estimate of 7,660,000, the board previously forecast a 1943 tuberculosis death rate of 48.5 per 100,000. The provisional rate in 1942 was 50.8.

The morbidity report showed that at the time of diagnosis 20.6 per cent of the cases were minimal, 34 per cent were moderately advanced and 41.69 were far advanced. Figures in each classification vary less than two per cent from those of 1942.

In the breakdown according to age and sex, the figures show more cases among females between the ages of five through 24 than among males. Of the 2,842 known cases among females approximately 16 per cent were among those in the age group 20 through 24. From birth through age four there were more male cases, and from 25 through 55 years and upwards male cases show an increasing lead. Among males known cases, those 55 and older represent approximately 21 per cent of the 5,027 total for the sex; among females in the same group, only 11 per cent.

Mortality figures for the sexes show the highest number of female deaths in the age group, 20 through 24 and for males, 55 through 59. Each five year group for females showed more than 100 deaths per group from the ages 15 through 39. Similarly, among males each of these groups showed more than 100 deaths from 20 through 74 years. More than 200 deaths were recorded for males in each five-year group between the ages of 35 through 64.

(Continued on Page 108)

TUBERCULOSIS ORGANIZATIONS IN AMERICA

The National Tuberculosis Association was organized in 1904 for the purpose of "studying tuberculosis and spreading knowledge as to its causes, treatment and prevention." The National Association is the nominal head of more than 2,000 local groups which carry on work in all forty-eight states, in Alaska, Hawaii, and Puerto Rico.

Each of these associations studies the problem in its own area and, working with the medical societies and the public health agencies, has moved toward the final eradication of tuberculosis.

The work of the Tuberculosis Associations in America is supported by the annual sale of Christmas Seals which, in 1943, provided more than twelve million dollars. (The 1944 Christmas Seals, designed by Spence Wildey, go on sale November 20.)

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1790 Broadway, New York City, 19

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A Federation of 61 Local Associations

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(Continued from Page 105)

The morbidity, but not the mortality, report, also gives figures by age, according to race and sex. For Negro females the most cases were in the group 20-24 years; males, 25-29. Among Mexicans, both male and female the age groups 15-19 and 20-24 were practically on a par. Strangely, among the Chinese males the age groups starting with 15 years and continuing through 55 showed little difference, while among females the cases were concentrated between the groups 15-19 and 19-24.

Cases not allocated to California counties, but according to the states of origin of the individuals totaled 615. Of these New York was in the lead with 59; Oklahoma second, 44, and Illinois and Texas, 43 each.

Tuberculous Veterans to Get Proper Care Experts Say

That the tuberculous veteran of World War II will not lack for adequate care for his own welfare and the protection of others seems more than likely, according to statements made by nationally known speakers at a joint medical and public health session of the recent fortieth annual meeting of the National Tuberculosis Association in Chicago.

The speakers were: Louis I. Dublin, Ph.D., third vice president and statistician of the Metropolitan Life Insurance Co.; Col. Roy A. Wolford, assistant medical director of the Veterans Administration; T. O. Kraabel, director of the national rehabilitation committee of the American Legion and Col. Esmond R. Long, of the office of the surgeon general.

Least optimistic of the speakers was Dr. Dublin, who termed legislation designed to aid tuberculous veterans of World War I "stupid and incompetent." He charged that young veterans of this war are rapidly "learning the tricks" by which the older men in these institutions violated the rules and came and went as they desired. Only the most sweeping reforms, according to Dr. Dublin, will prevent reoccurrence of the tragic errors made in the handling of this problem since World War I.

"There is every reason to believe that the end results in the treatment of the tuberculous veterans of World War II will be better than those attained in veterans after World War I," Col. Wolford said. He based this conclusion on statements showing that more complete thoracic surgery is now available in veteran hospitals, rehabilitation services, occupational therapy and entertainment features are more conducive to the patient staying until discharged. The veteran of today is better educated and understands his problem better, and the Army and Navy are impressing the soldier and sailor with the seriousness of his case and the need for early definite treatment.

Col. Wolford presented figures that indicated that although there still remains the problem of veterans leaving the hospitals before medical discharge, it has past its most serious stage. For the 12 months ending June 30, 1943, 61 per cent of the veterans of World War II who left the hospitals did so without medical consent. By February, 1944, the number so leaving has fallen below 40 per cent. Likewise the length of stay in the hospitals of the veterans has lengthened. Since July, 1942, the average was 110 days, while for the month of February, 1944, it was 123 days.

Col. Wolford recommended that the recalcitrant veterans be treated the same by local and state health departments as the recalcitrant tuberculous non-veteran.

"We believe," said he, "that the public health control of the tuberculous veterans, their education to continued treatment and their ultimate rehabilitation cannot be separated from the control, education and rehabilitation of the tuberculous non-veteran individuals of the community. Any and all measures that can be applied must be directed to and for the tuberculous population as a whole. There can be no veteran or non-veteran approach. The scope cannot be limited to Federal or State units; it must reach the smallest of the city and community units.

"Effective support through legislation and by appropriated funds, either private or public, must be given to insure adequate local, state and federal tuberculosis control measures, to further the extension of present treatment facilities and to broaden established rehabilitation programs, for all groups."

Mr. Kraabel left no doubt that the American Legion and the Auxiliary has made a thorough study of the subject of care for the tuberculous veterans, that they were aware of the weaknesses of the past program, that they had carefully weighed the various proposals put forth to remedy these mistakes and that they are prepared to participate actively and to coöperate with all other agencies enlisted in the fight against tuberculosis among veterans.

"The objective for our campaign," Mr. Kraabel asserted, "is to reduce markedly the number of those who depart from Veteran's Administration hospitals without leave and against doctor's advice."

In attempting to attain this objective the Legion and the Auxiliary will not be satisfied with mass appeals, but will train members to deal directly with individual patients and their families to persuade them not to leave hospitals until medical consent is received. They will also attempt to influence those veterans who already have left without consent to return, Mr. Kraabel said.

Col. Long pointed out that it is estimated that 130,000 men have been rejected at induction stations because of tuberculosis and that approximately 65,000 of these may be active cases.

"Review of x-ray films of men accepted for the Army indicates there may be 10,000 soldiers in the Army with small lesions not detected at the time of examination," Col. Long said.

"X-ray examination of men in the Army is frequent, and cases discovered are hospitalized for observation and care, and all active cases are discharged to the Veterans Administration. Two years ago the admission rate for tuberculous cases into Army hospitals was 2.3 per 1000 men per year. The rate gradually has declined from the figure to the present low rate of approximately 0.8. The improvement is believed chiefly due to experience and increased effectiveness in induction station examiners in the detection of early cases of the disease."

Trailer Donated

Presentation to the Sacramento Tuberculosis Association of a new two-wheel trailer to be used in transporting portable x-ray equipment has been made by the American Legion Post No. 209, Elk Grove. The x-ray equipment, which takes miniature chest films, was purchased by the association through Seal Sale funds and was placed in operation at the beginning of the year.

The x-ray has been used extensively in the county in programs held recently in Courtland, Folsom, Galt and Elk Grove. In Galt and Elk Grove 358 films were taken, 171 of high school pupils and 187 of adults.

Tuberculosis Deaths Head Reportable Diseases

More people died of tuberculosis in Los Angeles than from all other reportable diseases combined, according to a report to the Health Commission by Dr. George M. Uhl, City Health Officer.

He stated that there were 922 deaths from tuberculosis in 1943, or 53 per 100,000 of population, that 40 per cent of the tuberculosis deaths are never reported as cases, and that only 16.8 cases were discovered in the minimal stage.

Declaring that less than 25 per cent of the cases are reported to the Health Department by private physicians, Dr. Uhl asserted physicians should be more tuberculosis-conscious, that this is one disease affected by isolation, and that only by early discovery and isolation of the disease, with follow-up contacts by the department, can it be influenced in Los Angeles.

Tuberculosis Biggest Health Problem In Alaska

Tuberculosis is by far the most important public health problem in Alaska. At least two factors now stand in the way of an effective program for its control; the lack of anything even approaching adequate hospital facilities, and the failure of the white population to understand the seriousness to them of the great numbers of cases among the natives.

Methods of finding and reporting cases are very poor and there is an astonishingly large number of deaths that occur without any medical attendance so that the cause of death is given as "unknown." The figures for tuberculosis deaths are admittedly incomplete for these reasons. Even so they represent death rates for whites of 48 per 100,000. The rate for the United States among white persons in 1940 was 37 per 100,000. The native death rate of 728 is nearly 15 times the rate for the United States.

California Leads in Seal Sale Totals

Returns by California counties for the 1943 and 1942 sales follow:

Association	1943	1942
Alameda	$ 73,947.33	$ 62,091.80
Alpine	62.00	62.50
Amador	1,400.00*	1,354.77
Butte	7,500.01	5,029.18
Calaveras	1,041.16	843.78
Colusa	2,620.49	1,758.10
Contra Costa	24,799.29	19,762.50
Del Norte	770.50	646.85
El Dorado	1,699.99	1,484.75
Fresno	27,907.92	19,590.27
Glenn	1,910.52	1,137.80
Humboldt	4,348.81	3,349.52
Imperial	5,314.68	3,252.27
Inyo	1,218.45	1,065.92
Kern	21,750.09	12,291.92
Kings	3,640.68	2,508.51
Lake	1,153.25	763.12
Lassen	1,851.75	1,666.97
L. A. City	202,067.21	143,355.60
L. A. County	86,600.24	61,438.11
Long Beach	34,776.37	23,918.99
Pasadena	29,223.74	20,054.71
So. Pasadena	1,829.39	1,845.46
Madera	4,226.02*	2,797.61
Marin	6,860.35	5,000.00
Mariposa	654.20	599.66
Mendocino	4,530.09	2,300.81
Merced	8,416.43	5,612.03
Modoc	1,383.01	1,266.31
Mono	270.00	169.50
Monterey	15,618.33	11,082.09
Napa	8,530.30	6,127.75
Nevada	1,473.18	1,492.25
Orange	25,909.79	16,404.20
Placer	2,587.19	1,848.38
Plumas	2,318.81	1,627.34
Riverside	19,346.40	11,231.42
Sacramento	32,947.04	21,416.24
San Benito	697.18	615.74
San Bernardino	26,959.83	13,413.86
San Diego	53,511.05	31,881.83
San Francisco	114,538.80	84,718.39
San Joaquin	19,392.43	12,464.17
San Luis Obispo	5,463.06	3,084.96
San Mateo	23,981.15	16,564.19
Santa Barbara	18,802.67	13,727.63
Santa Clara	35,032.21	26,347.44
Santa Cruz	7,620.00	5,688.31
Shasta	4,554.22	3,132.70
Sierra	561.60	337.76
Siskiyou	3,722.15	2,977.11
Solano	16,930.91	12,653.23
Sonoma	15,935.01	10,267.44
Stanislaus	9,352.49	7,052.79
Sutter	1,452.97	1,162.40
Tehama	1,845.73	1,015.80
Trinity	514.00	519.25
Tulare	12,806.93	5,408.31
Tuolumne	1,065.31	905.00
Ventura	14,127.48	9,493.66
Yolo	5,030.73	3,305.69
Yuba	2,296.10	1,283.26
TOTAL	$1,068,744.70	$746,270.00

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* Unofficial estimate.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Medical Students

The President flatly refuses to approve the granting of occupational deferments to pre-medical students. (See CALIFORNIA AND WESTERN MEDICINE, for June, on page 32, for President's statement.)

It would strike laymen that there should be a way to effect a compromise. Certainly not every man who enrolls as a medical student should be draft exempt. But to be safe there should be a survey of the field looking toward the education of a sufficient number of young men who have the natural qualifications and are sincerely interested in the profession. Of the men now returning, a certain number may well be trained. The medical profession, through its journal, says there will have to be many more or the next few years will witness an acute shortage, the blame for which must be borne by those who refuse to look at the figures and heed the warnings. —Edtorial in Oakland *Tribune,* July 6.

Military Deferment of Medical Students Urged—Re: Recent Selective Service Directive Nullifying

Deferments

The Connecticut State Medical Society through its Committee on Public Relations, has urged Clare Boothe Luce, Representative in Congress from the State's fourth district, to support the passage of an amendment to the Selective Service Act to provide for a continuous flow of medical students. The bill, introduced by Congressman Miller of Missouri and now pending before the Committee on Military Affairs of which Mrs. Luce is a member, calls for the deferment each year of not less than 6,000 medical and pre-medical students.

The action of the Medical Society was stimulated by the prevailing policy of the Army and the Selective Service System, under which placing of medical students on inactive status in the enlisted reserve pending the completion of their studies has been discontinued. Up to now, government officials have apparently realized the necessity for maintaining continuous medical education of a high quality in the United States. Evidently pressure has been brought to bear which has caused them to disregard future medical needs and to gamble with the health of the nation.

The Secretaries of the War and Navy have opposed deferment of medical students on the ground that it would provide immunity from military service for five or more years to a selected group of young men. This opposition is maintained notwithstanding the fact that persistence in the failure to grant deferments will greatly reduce the number of graduates in medicine in 1948 and 1949. It seems entirely possible that the number of doctors coming into the profession every year will actually be smaller than the 3,500 who die each year.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

The release by 1948 of many doctors now in military service, which is put forward as an argument against deferment, is by no means an answer to the problem. The number of men released will not compensate for the deficit in new graduates for it can hardly cover the rapidly growing demand for physicians. There must be doctors enough to fill hospital requirements for internes, to provide medical care for the expanded program of the Veteran's Administration, to supply the needs of our allies and the people of liberated countries whose medical schools have been closed and whose physicians have been taken as prisoners. At a time when the whole world faces a need for well-trained physicians which is greater than ever before, government officials seem willing to *cut off the supply at the source.*

This problem, involving as it does the health of the Nation, is sufficiently important to demand that the most careful and serious consideration be given to the bill which proposes to remedy a dangerous situation.

Santa Clara County Medical Society Establishes a "Medical Disaster Relief Committee"

The emergency medical division of the office of civilian defense in Santa Clara County has been changed into a medical disaster relief committee by the Santa Clara County Medical Society, acting in accordance with a recommendation from the California Medical Association, City Health Officer Dwight M. Bissell, who is chairman of the new group, announced.

Dr. Bissell was appointed by the president of the county medical society, Dr. George Gray. The committee has arranged to include representatives of hospital organizations, nurses, volunteer ambulance units, dentists and pharmacists as well as physicians and surgeons. In case of earthquake, flood, fire, a train wreck, or other holocaust, the committee will aid victims in coördination with the disaster committee of the American Red Cross, of which Mrs. Frank Reidy is chairman.

The Red Cross will furnish participating nurses' aides, medical supplies, food and shelter in case of a disaster. The medical disaster committee will furnish professional medical and nursing care, and utilize surgical equipment formerly provided for the emergency medical service of the OCD, while air raids still seemed a serious threat.

Service Statistics on Defective, Disabled, Deficient, Disordered and Diseased Inductees

America was a flabby, soft, ailing Nation, staggering under a load of damaged health, illiteracy and emotional instability at the start of the war, Selective Service officials said on July 10, at a Senate hearing.

Major General Lewis B. Hershey, Selective Service director; Colonel Leonard Rowntree, medical director, and Captain C. R. Wells, chief of dental section; told the Senate Sub-Committee on Wartime Health and Education that lack of physical fitness of one-third of the population constitutes a "major manpower problem" and a threat to the survival of democracy.

The officials declared that so large a part of the population, mentally sick, uneducated, riddled with venereal diseases, and depleted by other illness, justified Federal measures and funds to put the Nation in sound health for present war needs and for post-war progress.

They said that, despite the rehabilitating the Army and Navy have done to reclaim and reclassify 4-Fs, the "country is ailing and should have medical attention."

"Selective service found the young men of the Nation flabby, soft and in need of conditioning," Rowntree told the committee at the opening of a three-day hearing.

"Instead of a country of rugged, virile men, we have a lot of 5-D's,—defective, disabled, deficient, disordered and diseased.

"Health is a major manpower problem and it will require the all-out effort on the part of everyone to correct this situation and prevent a recurrence."

Figures offered by Hershey and Rowntree showed that of the 4,217,000 4-F's, "the bottom of the manpower barrel," more than 16 per cent were disqualified for mental diseases, over 13 per cent for mental deficiency, and over 57 per cent for physical defects. Of those disqualified for physical defects, more were passed by for venereal disease than any other cause except heart ailments. Hernia was the third highest cause for rejection.

Both officials pointed out that figures on rejections were "like an iceberg, only a small part showing, the real danger below the surface, in the civilian population."

Officials recommended a program of public clinics, tied in with private practicing physicians. Rowntree recommended "a year of physical fitness, beginning September 1, 1944." He said that a national committee was coöperating with the American Medical Association on this.

Clinical Psychologists Aid Army

Clinical psychologists commissioned in the Adjutant General's Department are being made available for assignment to the Office of the Surgeon General for the neuropsychiatric sections of named and numbered general and station hospitals of 1,000 beds or more, the War Department announced on July 1, 1944. Requisitions for such officers will be forwarded to the Adjutant General through commanding generals of service commands concerned, or theater commanders when applicable.

Clinical psychologists will be assigned to duty in the neuropsychiatric sections of the hospital to serve under the direction and supervision of the chief of the neuropsychiatric section. Their duties will be to—

a. Aid in the development and administration of the program of counseling designed to prepare convalescent patients for return to military service.

b. Assist in the preparation of clinical records, particularly including those requiring the use and interpretation of special psychological tests as desired by the chief of the neuropsychiatric section.

c. Assist in studies of special psychological problems related to the classification and retraining of neuropsychiatric casualties.

d. Assist in the determination of the appropriate military occupational specialty of men who are designated as ready for assignment, and to advise regarding their assignment to a specific duty or special training.

e. Perform such other professional and administrative duties in the hospital as will best assist the neuropsychiatrist in the accomplishment of the best management and disposition of patients.

Decorations for Scrub Typhus Control Service

The Bronze Star Medal has been awarded to an officer of the Sanitary Corps and seven enlisted men of the Medical Department for their services in the prevention of scrub typhus on Goodenough Island in the South Pacific as announced on May 16, 1944, by the Sixth Army Headquarters.

Although these men were fully aware of the danger of contracting scrub typhus, they voluntarily applied themselves to the task of preparing camp sites in order to bring about the rapid and complete control of this disease on Goodenough Island. Their services were rendered during the periods of December 27, 1943 to February 7, 1944, and March 13-22, 1944.

Col. George K. Rhodes, Former San Francisco Surgeon, Dies in England

In California and Western Medicine, for June, 1944, on page 335, appeared an interesting letter received from Dr. George K. Rhodes concerning his experiences in England.

A news dispatch appearing in the "San Francisco Chronicle" of August 2nd, brings the following news of his death:

Lieutenant Colonel George K. Rhodes, 55, one of San Francisco's most brilliant surgeons and head of the University of California Base Hospital unit in the European theater, succumbed to a heart attack somewhere in England, it was learned here on August 2. Although details of Colonel Rhodes' death are not yet known, it is believed he died July 23.

Colonel Rhodes went overseas in June of 1942 and last April was appointed consulting surgeon of the American Army Forces for a large area of England.

Letters received here since D-Day indicated he went into Normandy with the first assault wave and was instrumental in establishing the first American base hospital in France.

A native of Utah, Colonel Rhodes received his medical education at Johns Hopkins where he interned. He was resident at the Roosevelt Hospital in New York and served overseas as a Major during the last war.

He came to San Francisco in 1920 and the following year was named chief assistant surgeon of the city's emergency hospital system, a post he held until he enlisted in the Army. He also was assistant clinical professor of surgery at the University of California Medical School.

He became an associate of Dr. Edmund Butler in 1928.

Among the organizations to which Dr. Rhodes belonged are the Pacific Coast Surgical Society, the Western Surgical Society, the American College of Surgeons and the American Medical Association.

He leaves his widow, Mrs. Wilma Rhodes.—San Francisco *Chronicle*, August 2.

Postwar Training of Medical Corps Officers

The Office of the Surgeon General has announced the appointment of a committee to formulate plans for postwar training of Medical Corps Officers who will be separated from the military service at the end of the war. The committee consists of: Brig. General Raymond W. Bliss, Chief of Operations Service—*Chairman;* Brig. General James S. Simmons, Chief of Preventive Medicine Service; Colonel James R. Hudnall, Chief of Personnel Service; Brig. General Fred W. Rankin, Director of Surgery Division; Brig. General Hugh J. Morgan, Director of Medicine Division; Colonel Floyd L. Wergeland, Director of Training Division; Colonel William P. Holbrook, M. C. and Lieut. Colonel R. E. Meiling, M. C., representatives from the Army Air Forces; Colonel R. B. Skinner, M. C. representative from the Army Ground Forces; George B. Darling, M. D., representative from the National Research Council.

U. S. Army Blind Centers

The Army Medical Department has designated two hospitals, namely, Valley Forge General Hospital, Phoenixville, Pa. and Dibble General Hospital, Menlo Park, California, as blind centers where all blinded casualties are being sent to receive a preliminary course in social rehabilitation while undergoing any necessary medical or surgical treatment.

Military Clippings.—Some news items of a military nature from the daily press follow:

Service Men and Health Insurance

Next after the qualities of our Generals, in the strategic and tactical leadership that wins wars and battles, and the fighting courage and training of the officers and men under them, come the vast resources and industrial and transport facilities of America, which supply them with the equipment to win the victory. Next after these come the workers and managers of American industry, who are fighting the war of production on the home front.

And behind them are the American people, who, with all the divisions of viewpoint which are inevitable in a democracy, are nevertheless united in the determination to win the military war, and are far more understanding than the politicians in recognizing that the post-war problems, economic, governmental and intergovernmental, must also be met in the new world which scientific advance has now brought too close together to make old-style nationalistic isolation any longer possible.

But on the strictly human side, the greatest triumph is unquestionably the medical one. By the dread arithmetic of war, "casualties" are the sum of those subtracted from the immediate fighting force, killed, wounded, prisoners and missing. But as a human fact, to families and friends at home, to whom each soldier is a separate individual, the only ones as to whom the tragedy is total and permanent are the dead. For all the others there is some measure of hope. And this applies particularly to the wounded and to those disabled by disease.

In all previous wars, wounds and disease carried off far more than those directly killed in action. This was true even in the last World War, when many thousands died of injuries or illness which would be curable or preventable now. And in the earlier wars it was a wholesale disaster.

Now the danger of death to the wounded is, by comparison, almost negligible, and even the severely maimed are largely secure against helpless permanent disabilities. They all have a better chance in the army now than almost anybody in civil life ever had before.

The doctors have done this. . . .

When these soldiers come home, having learned what can be done to save life and health by an organization of medical service which, on its business—not its professional—side, is on a basis the reverse of last century tradition, they will be satisfied with nothing less adequate in civil life.

And this time, if the returning service men know what they want, we may be very sure that they will get it, no matter who dissents.—Chester Rowell in San Francisco *Chronicle*, July 18.

War Is Cutting Doctor Supply 2000 Year

Chicago—(AP.)—The present policies of the armed forces and selective service will result in an annual deficit of 2,000 doctors each year after the war, the *Journal of the American Medical Association* declared on July 5.

Terming the predicted shortage of physicians an "alarming situation," the *Journal* asserted:

"The responsibility must rest with the armed forces, the selective service system, the President and the Congress of the United States."

The *Journal's* editorial appeared as President Roosevelt in Washington declined to interfere with a Selective Service Board order banning occupational draft deferments for pre-medical students after July 1.

"Although schools will continue the accelerated program, they will admit classes only once annually instead of every nine months. This of itself will reduce the number of graduates from the present annual average of 7,000 to 5,000," the editorial said.

"If classes can be only half filled, this number will be reduced to 2,500 graduates per year. Since 3,300 to 3,500 physicians die each year, there will result an annual and cumulative deficit of 2,000 doctors a year."

The editorial recommended "full support" of a bill by Representative Miller (R-Neb.) proposing deferment of at least 6,000 medical students and 4,000 dental students in each calendar year.—Sacramento *Union*, July 6.

The five most common causes of the deaths of school children in the United States are, in the order named, accidents, appendicitis, influenza and pneumonia, rheumatic fever, and tuberculosis.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Democratic and Republican Platforms

Their Provisions Concerning Public Health and Medical Service

Both political parties have recently concluded their conventions in Chicago. The platforms adopted might well be studied by physicians, at least to the extent to which they reflect the attention the Federal Government will possibly devote to programs when the new Congress convenes early in January of next year.

The Democratic Platform.—Here are the planks in the Democratic platform that refer directly or indirectly to a health program:

"Beginning March, 1933, the Democratic Administration . . . provided social security, including old age pensions, unemployment insurance, security for crippled and dependent children and the blind. . . . We pledge the continuance and improvement of these programs. . . .

"We offer these postwar programs:

"A continuation of our policy of full benefits for ex-service-men and women with special consideration for the disabled. . . .

"The enactment of such additional humanitarian, labor, social and farm legislation as time and experience may require, including the amendment or repeal of any law enacted in recent years which has failed to accomplish its purpose. . . .

"We reassert our faith in competitive private enterprise free from control by monopolies, cartels, or any arbitrary private or public authority."

* * *

The Republican Platform.—Under the heading "Security," this is what the Republican platform has to say about federal participation in health and allied fields:

"We pledge our support of the following:

"1. Extension of the existing old age insurance and unemployment insurance system to all employees not already covered.

"2. The return of the public employment office system to the states at the earliest possible time, financed as before Pearl Harbor.

"3. A careful study of federal-state programs for maternal and child health, dependent children, and assistance to the blind, with a view of strengthening these programs.

"4. The continuation of these and other programs relating to health, and the stimulation by federal aid of state plans to make medical and hospital service available to those in need without disturbing doctor-patient relationships or socializing medicine.

"5. The stimulation of state and local plans to provide decent low cost housing properly financed by the federal housing administration, or otherwise, when such housing cannot be supplied or financed by private sources."—Medical Service Bulletin No. 13, A.M.A. Council on Medical Service and Public Relations.

Deferment of Premedical Students

California and Western Medicine, for July, on pages 2, 30, and 32 presented comment on the menace to future medical standards that will result from the Selective Service ruling which banned deferment of premedical students beyond July 1, 1944.

The California Medical Association has sent the following letter to California Senators and Congressmen. Since some of the Congressmen are now in California, during the Washington, D. C., recess, officers of component county medical societies may wish to call to their attention the importance of the problem. A roster of Congressmen with home addresses appeared in California and Western Medicine, for July, 1943, on page 85.

The letter which follows was sent to California Congressmen at their Washington addresses. C.M.A. members who personally know, or who, as constituents, wish to write to their respective Congressmen concerning H.R. 5128, may feel free to do so.

* * *

(copy)

California Medical Association
Four Fifty Sutter, San Francisco, 8
July 29, 1944.

Hon. ————,
Congressman ——— California District,
House Office Building,
Washington, D. C.
Dear Congressman ————:

Your attention is called to House Resolution 5128 introduced by Congressman Louis E. Miller of Missouri which would provide that not less than 6,000 medical students, and not less than 4,000 dental students be granted deferment in each calendar year (students to include pre-medical and pre-dental students).

The California Medical Association approves H.R. 5128, since, if it is not enacted, a serious shortage of well-trained physicians to care for future military and civilian needs will result.

The following figures give further information on the physician shortage which will arise:

Should an adjustment not be made to correct the present alarming situation, a tremendous reduction of graduates after the war will ensue. Although schools will continue the present "accelerated program," they will admit classes only once annually, instead of every nine months. This of itself will reduce the number of graduates from the present annual average of 7,000 to 5,000. If classes can be only half filled, this number will be reduced to 2,500 graduates per year. Since 3,300 to 3,500 physicians die each year, there will result an annual and cumulative deficit of 2,000 doctors a year. Other factors, such as military needs and retirement from practice must also be considered.

* * *

The California Medical Association asks your support of H.R. 5128 (Miller) which provides:

"(n) There shall be deferred from training and service under this Act in the land and naval forces of the United States, as necessary to the maintenance of the national health, safety, and interest, in each calendar year not less than six thousand medical students" . . .

May we hope to hear from you in regard to the above?

Cordially yours,
The Council of the
California Medical Association,
Lowell S. Goin, M.D., *President.*
(Signed) George H. Kress, M.D., *Secretary.*

Buck's Extension.—So readily apparent was the value of Gordon Buck's system for obtaining traction of the thigh that it was at once adopted by the medical profession as important adjunctive treatment in fractures. This treatment, together with the Thomas Splint, was widely used with success during the First World War. It is still known as "Buck's Extension." Boldness in operating and thorough after-care were his characteristics as a surgeon.—Warner's *Calendar of Medical History.*

MATERNITY-PEDIATRIC PLAN OF FEDERAL CHILDREN'S BUREAU*

ITEM LIV

On Medico-Legal Aspects of Regulation "Form M" of Federal Children's Bureau†

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, June 15, 1944

Subject: Enclosed Letters: Marked Exhibit I to Exhibit VI, Inclusive, the same being legal opinions concerning use of certain words, *Complete* and *Required*, in the Federal Children's Bureau E.M.I.C. "Contract."

The Members of the C.M.A. Committee on Maternity-Pediatric Care, Addressed.

Dear Doctors:

The enclosed letters, received by Dr. William Benbow Thompson of Los Angeles, have relation to possible malpractice complications in connection with the E.M.I.C. program.

In reading the original E.M.I.C. "Form M" contract, the thought occurred to Dr. Thompson that physicians who sign the original contract might be laying themselves open to extra malpractice liability. Further, that if such should be the case, the commercial carriers might be reluctant to protect physicians who sign such contracts insofar as the said work is concerned.

The enclosed communications are of interest in their protrayal of phases of legal responsibility of physicians.

* * *

After receipt of these communications, the matter was discussed with the representatives of the State Board of Public Health, and a new "Form M" is now under consideration by the C.M.A. Committee on Maternity-Pediatric Work, of which Dr. Karl L. Schaupp is chairman.

A new revised form will be forwarded to the Federal Children's Bureau by the Bureau of Maternal and Child Health of the California State Board of Public Health. It is hoped that the same will receive approval by the Washington, D. C., authorities.

The above for your information.

Cordially yours,
C.M.A. COMMITTEE ON E.M.I.C.,
Karl L. Schaupp, M.D., *Chairman,*
By George H. Kress., M.D.,
Secretary-Editor.

Enclosures:

Exhibit I—Letter of W. M. Rains, Esq. (Medical Protective)

Exhibit II—Letter of W. W. Vaughn, Esq. (Lloyds)

Exhibit III—Letter of Louis J. Regan, M.D., Esq. (Los Angeles County Medical Assn.)

Exhibit IV—Telegram of J. W. Brown, Esq. (Home Office, Medical Protective)

Exhibit V—Letter of H. F. Peart, Esq. (Legal Counsel, C.M.A.)

Exhibit VI—New proposed "Form M" (as revised for California)

EXHIBIT I

(COPY)

Law Offices
WILLIAM M. RAINS
Los Angeles, 13
June 2, 1944

My dear Dr. Thompson:

You have asked me to examine E.M.I.C. from "M" to report to you concerning the contractual and legal aspects of the language of that portion of said form designated "Physician's Request for Authorization for Medical and Hospital Service for Maternity Patient."

I find the following excerpt therefrom to be criticizable:

"Complete Maternity Service (Required by this patient from date of application through six weeks' postpartum period.)

"1. Complete medical services including: Prenatal care including taking blood for test for syphilis, hemoglobin determinations and urinalyses, care during labor and the puerperium, as well as care of complications, obstetric operations if needed, postpartum care, care of the newborn infant and a postpartum examination six weeks after delivery."

The use of the terms "complete" and "required" imply a legal undertaking and responsibility considerably beyond that which is demanded by the law and the above excerpt from the proposed application imposes a liability upon a physician who signs it in excess of the obligations which the courts have placed upon physicians and surgeons in the treatment of their patients.

In this connection the Supreme Court of California has announced the rule and has followed the precepts laid down in virtually all other jurisdictions in this country. I quote from the case of *Hesler v. California Hospital Co.*, 178 California Supreme Court Reports, page 764 at page 767:

". . . The law, as above stated, does not require that the instructions and advice given by a physician to a patient should be at all events and beyond question 'proper,' or that his treatment should be certainly such as to obtain an approximately perfect result. *It requires only, first, that he shall have the degree of learning and skill ordinarily possessed by physicians of good standing practicing in that locality, and, second, that he shall exercise reasonable and ordinary care and diligence in treating the patient* and in applying such learning and skill to the case. The law takes cognizance of human weakness and liability to err in the application of skill and learning, and it requires only the exercise of reasonable and ordinary care and diligence to avoid error. These instructions require more; they require that the advice given shall be 'proper,' which implies that no error shall be committed; they require that the physician shall do everything necessary to be done to produce an approximately perfect result; that he guarantees that his treatment shall be that of quality; whereas the law only demands that he use reasonable care to attain such approximate perfection. Instruction 9 declares that the physician is bound to use, and of course to have, a degree of skill 'adequate' to the performance of his undertaking; the law requires that he have the degree of skill ordinarily possessed by reputable physicians practicing in that locality. This may or may not be 'adequate' to the performance of his undertaking, according to the meaning to be given to the word 'undertaking'."

A careful and precise reading of the above quoted language of the California Supreme Court will disclose that the word "proper" which is under attack by the California Supreme Court is almost a perfect paraphrase for either or both the words "complete" and "required" as used in E.M.I.C. form "M" and it can be at once seen that *any physician undertaking to render complete or required service is virtually undertaking and contracting to render "proper" attention. If he affirmatively contracts to do so he is accepting a legal responsibility which, as I have suggested above, is greater than the law requires.*

---

* Maternity-Pediatric items listed in Roman numerals. CALIFORNIA AND WESTERN MEDICINE for July (Items I to XVIII); September, pages 178-182 (Items XIX to XXIII); October, pages 226-231 (Items XXIV to XXX); November, pages 282-284 (Items XXXI to XXXVII); December, page 342 (Items XXXVIII and XXXIX and page 304), January, pages 31-32 (Items XL and XLI); February, pages 76-77 (Items XLII and XLIII); March, page 110 (Items XLIV and XLV); April, page 221 (Item XLVI); May, page 259 (Items XLVII to LI); June, page 34 (Items LII to LIII).

† See in this issue, Report of Dr. William Benbow Thompson, on recent Washington, D. C., Conference (Page 72).

I am furthermore unable to determine, having in mind a limitation of six weeks' treatment, what a physician was supposed to do in the event he found the pregnant patient was syphilitic or what he would be supposed to do in the event of the concurrence of any of the innumerable complications of pregnancy.

I am forwarding a copy of form "M" to the Medical Protective Company at Fort Wayne which I have represented here for approximately seventeen years. I do not know what their view of this situation might be, but my guess is that it would reasonably coincide with mine. *Insurance companies generally have "shied away" from maintaining insurance for professional men who enter into contracts in which they accept a liability beyond that required under the law.* It is my belief, therefore, that any physician undertaking to perform services under the present language of form "M" would not only expose himself to malpractice hazards not ordinarily contemplated, but also whoever *his insurance carrier might be would be very much inclined to cancel his insurance coverage because of the extraordinary risk engendered by this type of undertaking.*

Yours respectfully,
(Signed) William M. Rains.

* * *

Exhibit II

(copy)

Maddox & Vaughn
Attorneys at Law
Los Angeles, 14

June 1, 1944

Dear Dr. Thompson:

I must conclude that the contract which you have sent us would materially increase the duty that the physician owes to the patient. The phrase "as well as care of complications" is very broad indeed and it would take judicial interpretation to determine the scope of that language. I would therefore agree with you that the contract throws an extra burden upon the doctor, and, if he is insured, consequently upon the insurance carrier. I am sure most careful consideration would have to be given to the contract by insurance carriers before it could be determined whether those assureds performing this service under a similar agreement were not, in fact, subject to extra hazards and therefore should be charged additional premium.

But aside from the insurance companies' interest, it concerns us, for the reason that it might throw a liability on the doctor which would not be covered by his insurance. Policies of malpractice insurance do not cover actions for breach of *express* contracts. Ordinarily an attorney would bring the suit on the basis of malpractice, for damages would be considerably greater under such action. On the other hand, the proof is more difficult and it might be that he would bring suit for breach of contract, where there was in existence an agreement between the physician and the patient, such as the one you have sent us. *In that event there would be no coverage under the policy.*

Very truly yours,
Maddox & Vaughn,
(Signed) By W. W. Vaughn.

Exhibit III

(copy)

* * *

Louis J. Regan, M.D.
6777 Hollywood Boulevard

June 1, 1944

Dear Dr. Thompson:

The physician-patient relationship ordinarily arises on the basis of contract, generally an implied contract.

In undertaking the care of a patient a physician *impliedly* represents and agrees that he possesses and will exercise the degree of skill, knowledge and care ordinarily possessed and exercised by the ordinary reputable physician in the community in the care of similar cases. Thus the legal duty of the physician to his patient is indicated; thus the standard which the physician must meet is established.

The legal duty of the physician to his patient may be limited, varied, or *enlarged* by special contract. Furthermore, while in ordinary circumstances the physician may withdraw from the care of a patient by giving reasonable notice and allowing reasonable opportunity to fill his place, he may, as a result of special contract, be precluded therefrom without breach of contract. When a special contract exists containing clauses of particular services to be rendered, the term thereof, etc., the contracting party must fulfill his contract unless freed from liability for breach of contract by Act of God, mutual agreement to rescind, etc.

It is clear, in my opinion, that a physician, who agrees to care for a patient under the Emergency Maternity and Infant Care Program, enlarges his liability and limits his freedom of action as compared to the standards with which the physician is burdened in ordinary private practice. Physicians engaged in caring for patients under this program obviously become less desirable risks from the viewpoint of Carriers engaged in writing Physicians Professional Liability Insurance. When the Carriers become aware of the existence of this situation, it will, I believe, be reflected in increased rates or limitation of coverage.

Sincerely yours,
(Signed) Louis J. Regan, M.D., LL.B.

* * *

Exhibit IV

Copy of
Western Union Telegram

Fort Wayne, Indiana,
June 5, 1944.

Re: Federal aid under E.M.I.C. Program.

We have received copy William M. Rains letter June 2nd and affirm his criticism concerning "Form M" of Federal Children's Bureau.

All malpractice insurance is founded upon liability imposed by law and does not contemplate liabilities arising from special contract.

To avoid question on physician undertaking hazards not covered by their insurance, we suggest "Form M" should call only for *general maternity service* as the condition of patient may require in judgment of the attending physician, including usual pre-natal and post-partum care.

This will avoid question of specific service to be rendered, and would permit "Form M" to apply, regardless of variations in usual care in different communities.

The Medical Protective Company,
By: James W. Brown, Counsel.

EXHIBIT V

(COPY)

HARTLEY F. PEART
Attorney-at-Law
111 Sutter Street, San Francisco, 4

June 13, 1944.

California Medical Association,
Attention of Dr. George H. Kress, Secretary.

Dear Doctor:

Re: E.M.I.C. Program—Malpractice Liability

Receipt is acknowledged of your letter of June 12, 1944, and enclosures, including copy of opinion rendered by Attorney William M. Rains to Doctor Thompson. It appears that Mr. Rains believes that the present language of the E.M.I.C. contract form may result in a Court holding that obstetricians who sign such contract are liable to a degree of skill and care beyond the degree normally required. Mr. Rains points out that although a physician is ordinarily held only to average skill and care, he may by contract agree to exercise a higher degree of skill and care than the average. We are in accord with Mr. Rains' opinion. . . .

Very truly yours,

(Signed) HARTLEY F. PEART.

* * *

ITEM LV

Excerpts from Proceedings of Fifty-second Annual Session of Idaho State Medical Association—Re: E.M.I.C. Program

Report of Medical Advisory Committee on E.M.I.C.

The Emergency Maternal and Infant Care program of the Children's Bureau was the subject of scrutiny, deliberation and appropriate action at the time of the last meeting of the House of Delegates of this Association nine months ago. The program remains in full force and operates in practically the same manner today, not because it is less objectionable to American physicians, but because such a plan once put into operation by a powerful governmental agency can carry on indefinitely through its own inertia and only through difficult legislative action can it be impeded or stopped. . . .

During the past year resistance to the administration of the E.M.I.C. program by the Children's Bureau has consisted of action by the House of Delegates of the A.M.A., similar action by state and local organizations and other more or less authorized groups. . . .

Upon invitation by the Maternal Welfare Committee of the Washington State Medical Association, a conference upon the subject of E.M.I.C. was held in San Francisco in November, 1943. Members of the maternal welfare committees of the various western states were invited and five states were represented: Washington, Oregon, California, Arizona and Idaho. Some states had more than one representative and in addition there were in attendance representatives of the California State Board of Health and the western regional director of the Children's Bureau. As a result of this conference much that was new to most of us was learned about the machinations of the Children's Bureau in the promulgation of this program and it became very clear that the only manner by which we might escape the yoke of bureaucratic management would be by making ourselves heard by Congress, particularly by the House and Senate Appropriations Committees. Resolutions were drawn and copies sent throughout the country and to members of Congress. There followed an enthusiastic response by medical groups and publications, particularly from the middle west.

The result was calling a second conference in Denver during the last week in April, planned to precede the various State Society meetings and the meeting of the A.M.A. At this meeting nine states were represented and there were warm communications of support from numerous other states. The reports of a fact-finding committee and a resolutions committee will find their way to all State Medical Associations in the very near future. In general, they are in line with many previously published resolutions. Perhaps of more interest were the sidelights of information which developed during the course of the meeting.

Considerable time was given to the subject of characterization of the officials of the Children's Bureau. This bureau is under the Department of Labor and Secretary Perkins. Nominal head of the Bureau is Katherine Lenroot who is a trained social worker of middle age and described as charming, intelligent and able concerning the subject of social problems. Assistant chief of the Bureau is Dr. Martha Eliot, a graduate in medicine but whose practical experience consists only of social work, none in the practice of medicine. Next in line and said to be director of E.M.I.C., is Dr. Ed Daily, likewise a graduate in medicine but without practical experience. He was a graduate of the University of Colorado School of Medicine and known well by a number of the men attending the conference. It was he who first established the $35 fee, and argued for some time that it was adequate for any and all occasions. His type is perhaps best illustrated by some of his reported utterances. At the time of the establishment of this program in the State of Washington, he advised Dr. Percy Guy, then head of the M.C.H. program in the state: "Do not convene your committee nor consult any doctor. Tell them what to do and don't consider their opinions." At a recent meeting of Secretaries of State Societies and Editors, he is said to have taken quite a grilling, but ended with the remark, "This is the way it is going to be and you are going to like it."

A letter from Dr. Daily to Dr. Harold Morgan of Nebraska was read in answer to queries by the latter. The point of the letter was this. Specialists in obstetrics should not be concerned with the general execution of the program. It was not set up for specialists but for the general practitioners. According to the Children's Bureau plans, the former were never intended to be more than consultants (an obvious attempt to injure practitioners of medicine in the eyes of the public, inasmuch as they must have hoped for widespread refusal to take this work by the specialists).

The recent edict from the Children's Bureau to the effect that all illness or accident concerning a Service man's wife and/or children is to be cared for by American physicians for set fees up to a maximum of $50 was discussed. It was interesting to note that this proposal came out at the moment it was known that the Wagner-Murray-Dingell bill would not come out of committee. (Why bother about the Wagner bill if the Children's Bureau can by directive accomplish the same results by going a few steps further?)

H. E. DEDMAN, *Chairman*.

* * *

Comment by Earl Sage, Professor of Obstetrics and Gynecology, Nebraska:

The E.M.I.C. is a trial balloon for complete federalization of medical practice. Proponents of this scheme are observing the reaction of the medical profession and are deciding whether to make bolder strides toward their objective, or to retreat from their grandiose scheme. This E.M.I.C. program was enacted, not as an independent legislative proposal but as an amendment slipped into an important appropriation act.

This program was adroitly set up. It is under the guidance and direction of the Children's Bureau, and who has the temerity to oppose or even question that which emanates from such an agency? Would you not care for a little new-born? Shame on those of you who are unwilling to travel the path this bureau of your beneficent government has laid out for you.

Federal health and medical projects are seldom discontinued after an emergency and the E.M.I.C. program is probably no exception. This program can be used as a precedent to extend federal medical care to all branches of medicine and surgery. Dr. Eliot told Dr. Bauer of the A.M.A. that she does not deny the E.M.I.C. is an opening wedge, a foot in the door for broader plans.

The totalitarian State starts out as a welfare oufit. It promises the more abundant life to the extent that it makes the individual dependent upon the state from the cradle to the grave, and thus it obtains control over his life and vote. Let us not forget that the government of ancient Rome, that provided bread and circuses for the indolent, soon perished.

Chvostek's Sign.—Conscientious, eager, humane—Franz Chvostek found time to accomplish much in his professional life. He was one of the most eminent Austrian military doctors of the last century, and his contributions to literature numbered more than 150 articles on various medical subjects. Most of them, however, concerned the pathology and treatment of diseases of the nervous system. The sign, to which his name is attached, is easily elicited—it consists in the sudden spasm seen on tapping one side of the face.—*Warner's Calendar.*

COMMITTEE ON HOSPITALS. DISPENSARIES AND CLINICS

Nurses and Permanente Foundation In 5-Year Contract

A five-year contract covering salaries and working conditions of graduate registered nurses was signed by the Alameda County Nurses Association and by Dr. Sidney R. Garfield for the Permanente Metals Corp. and the Kaiser Co., it was announced today by Miss Jean Barthe, secretary of the Nurses' Association. The salary schedule provides a monthly rate of from $155 to $170 for general staff nurses; from $165 to $180 for surgical nurses, and higher brackets for supervisory, administrative and specialized nurse groups.

Indio Hospitals Ask Revision of Rates for Indigent Patients

Referred to the hospital committee on June 4, by county supervisors was the proposed new schedule of rates for payment of indigent care at private hospitals in the Coachella Valley.

Dr. B. Gene Morris, proprietor of the Casita Hospital at Indio, submitted a proposed schedule at $12 for the first day's care in surgical cases and $6 per day thereafter, with medical cases handled on a $7 per day basis. As an alternative proposal, Dr. Morris suggested a flat rate of $9.62 for all types of cases.

Dr. W. H. Blackman, of the Coachella Valley Hospital at Indio, by letter asked the supervisors to reconsider its present indigent care contract, calling for a $5 per day rate, on a basis of $7.50 per day, plus certain drugs and supplies.

Hospital Tax Cuts Granted

Acting in line with the policy of previous years, the Board of Supervisors, sitting as a board of equalization, on July 14, granted tax reductions to hospitals in Los Angeles County.

The action of the Board was taken following an appeal made by Attorney Joseph Scott on behalf of a number of Catholic hospitals. Not only was the reduction granted to the Catholic hospitals, but also to 28 other nonprofit and semicharitable hospitals throughout the county.

Non-Federal Hospital Building Plans

Proposed non-federal hospital building that will require an expenditure of $1,193,133,985 and will provide 180,626 new hospital beds may be anticipated on the basis of reports from 1,683 hospitals tabulated in a survey being conducted by John N. Hatfield, chairman of the committee on governmental aid for postwar construction of the council on governmental relations of the American Hospital Association. Mr. Hatfield, administrator of the Pennsylvania Hospital, Philadelphia, headed the committee investigating postwar hospital conditions in this country.

"In arriving at this conclusion," Mr. Hatfield said, "it is assumed that the non-reporting hospitals require expansion in the same ratio per existing beds as those coöperating in the survey."

Hospitals numbering 897 or 53.3 per cent of those reporting indicated some building plans, the committee reported. These institutions house 246,243 beds or 70.5 per cent of the facilities in the reporting hospitals. Reports were received from a broad cross section of the hospital field, including a 10-bed hospital planning to spend $30,000 and a 1,500-bed hospital planning to spend two million dollars for plant expansion.

Ninety-five of the reporting hospitals already have projects under way, 70 have definite plans for 1944, and 582 are leaving their plans for the postwar period.

A total of 74 hospitals reporting have cash on hand for financing of their postwar plans; 330 will need government funds, and the others will raise money from private financing, public campaigns or subscriptions, hospital income, miscellaneous or undetermined sources.

Hospitals and the War Effort

Hospitals' contribution to the war effort, both on the fighting and home front, will be brought to the attention of millions of persons through a series of radio programs sponsored jointly by the American Hospital Association and the United States Chamber of Commerce, according to Frank J. Walter, Denver.

"The Chamber of Commerce is planning to record six five-minute broadcasts to be distributed to at least 150 local radio stations by local units of the Chamber of Commerce," Mr. Walter announced. "These six broadcasts will be devoted to health and welfare activities of hospitals, their contribution to the war effort, maintenance of civilian health, and related subjects."

War effort by hospitals embraces the loss of tens of thousands of highly trained doctors, nurses, administrators, and technicians at a time when the patient load is at a record high. Evidence of these accomplishments will be set forth in the broadcasts, Mr. Walter said, as will the evolution of the duties of the hospital to the community and nation which have centered about the maintenance and restoration of health: Care of the sick and injured; prevention of disease and the promotion of health; education of doctors, nurses, and administrators and other personnel; and constant research in the sciences' contribution to good hospital care.

Hospital Staff Affiliations

A recent issue of the "Berkeley Hospital Bulletin," outlines staff qualifications as follows:

> The American College of Surgeons requires every hospital with a surgical department to give careful attention to supervision and control of surgical work so that the service will be kept up to acceptable standards. For the more successful and efficient performance of surgery in accordance with the standards recommended by the College, the Surgical Committee is engaged in the reclassification of the members of the Surgical Staff into various groups in accordance with their experience and training. Surgical Qualification Blanks have been sent to the Staff to determine the status of the members in the various fields of surgery. Surgeons of the Staff will be divided into two groups:
>
> Group I—Fully Qualified Surgeons
> Group II—Provisionally Qualified Surgeons
>
> Fellows of the American College of Surgeons will automatically be placed in the Fully Qualified Group, and diplomates of the various specialty boards will be fully qualified in their respective specialties.
>
> Qualifications for Group I are as follows:
>
> 1. Graduate of an approved medical school.
> 2. At least a one year internship in an approved hospital.
> 3. Two years or more as a surgical resident or as assistant to a senior surgeon who performed a large amount and variety of major surgery.
> 4. Assurance that candidate has done at least 100 major operations for which he is the responsible surgeon, all of which have been carefully recorded and show acceptable end results.
> 5. Recommendation by at least two men on the hospital staff who are fully qualified for surgery.
>
> Those who do not fully comply with these qualifications will be classed in Group II as provisionally qualified, and may do surgery only with a member of the Fully Qualified Surgical Staff as an assistant until the Chief of the Surgery Service approves advancement to the Fully Qualified Group.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (53)

Alameda County (3)

Kennedy, Bayles R., *Berkeley*
Koke, Helen M., *San Leandro*
Merrill, Malcolm H., *Berkeley*

Los Angeles County (36)

Anthony, Edward H., *Inglewood*
Bailey, Frank W., *Santa Monica*
Ballard, Francis E., *Los Angeles*
Beem, Richard T., *Culver City*
Burchy, Frederic W., *Pasadena*
Carlson, Herbert A., *Long Beach*
Coumbe, Jay Etzell, *Los Angeles*
Cuneo, Henry Michael, *Los Angeles*
Dakin, Marion Janet, *Los Angeles*
Feder, Ellen Wynne P., *Los Angeles*
Frank, Dee Edward, *Roscoe*
Garten-White, Ruth, *Whittier*
Hartman, Deane Clemens, *Los Angeles*
Hewitt, Arthur William, *Los Angeles*
Lighter, Andrew George, *Los Angeles*
MacLaren, Walter Rogers, *Burbank*
Marsh, Clemson, *Los Angeles*
Olson, Frederick A., *Los Angeles*
Pierce, Amor Francis, *San Fernando*
Poyet, Ellen Blanche, *Pasadena*
Preston-Brown, Frances M., *Los Angeles*
Reynolds, T. Gordon, *Los Angeles*
Richardson, Clark M., *Los Angeles*
Rubenstein, Max R., *Beverly Hills*
Sagnella, Lawrence A., *West Los Angeles*
Sauer, Kearney, *Los Angeles*
Seal, Alfred L., *Beverly Hills*
Shattuc, William Ellison, *Vultee Field*
Shutter, Lillian, *Los Angeles*
Smith-Swift, Gladys Grace, *Hondo*
Spies, John William, *Los Angeles*
Swift, Loren Clyde, *Hondo*
Stewart, Frank William, *Long Beach*
Tuben, Peter A., *Los Angeles*
Wells, Ruth, *Pasadena*
Williams, Wilburn J., *Los Angeles*

Riverside County (1)

Olson, Elmer H., *Riverside*

San Bernardino County (6)

Christensen, E. C., *Loma Linda*
Berglund, Hazel L., *Redlands*
Dunne, Gerald P., *San Bernardino*
Hughes, John E., *Loma Linda*
Phang, Samuel H., *Loma Linda*
Woodward, J. C., Jr., *Fontana*

San Diego County (2)

Klopfenstein, Fred C., *National City*
Villanueva, P. A., *National City*

San Francisco County (2)

Knight, Louise C., *San Francisco*
Richards, George H., *San Francisco*

San Mateo County (1)

Bierman, Jessie M., *San Mateo*

Santa Barbara County (1)

Loutfallah, Michel, *Santa Barbara*

Tulare County (1)

Dyck, George, *Tulare*

Transfers (1)

Procopio, S. J., from Los Angeles County to San Diego County.

In Memoriam

Crosby, Daniel. Died at Piedmont, July 15, 1944, age 69. Graduate of the Cooper Medical College, San Francisco, 1898. Licensed in California in 1898. Doctor Crosby was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Ely, Leonard Wheeler. Died at Palo Alto, June 17, 1944, age 76. Graduate of Columbia University College of Physicians and Surgeons, New York, 1895. Licensed in California in 1914. Doctor Ely was a Retired Member of the Santa Clara County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

◆

Fisher, Carl. Died at Los Angeles, June 7, 1944, age 64. Graduate of Harvard Medical School, Boston, 1905. Licensed in California in 1920. Doctor Fisher was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

◆

Koepke, Frederick Herman. Died at Watsonville, May 18, 1944, age 63. Graduate of the Cooper Medical College, San Francisco, 1903. Licensed in California in 1903. Doctor Koepke was a member of the Santa Cruz County Medical Society, and the California Medical Association.

◆

Moore, Edward Clarence. Died at Los Angeles, July 10, 1944, age 62. Graduate of the University of Southern California School of Medicine, Los Angeles, 1904. Licensed in California in 1904. Doctor Moore was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Pinkham, Charles Bradley. Died at Atherton, July 14, 1944, age 72. Graduate of the New York Medical College, Flower and Fifth Avenue Hospitals, New York, 1899. Licensed in California in 1900. Doctor Pinkham was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Williams, Edward Huntington. Died at Santa Monica, June 24, 1944, age 75. Graduate of the State University of Iowa College of Medicine, Iowa City, 1892. Licensed in California in 1914. Doctor Williams was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

OBITUARY

Charles B. Pinkham

1873—1944

Charles B. Pinkham was born in Morristown, New York, in 1873. His parents coming to California, he was graduated from the Sacramento High School in 1891, receiving the degree of A.B. from Stanford University in 1896. He attended the New York Homeopathic Medical College, receiving his M.D. degree in 1899. In competitive examination he obtained the post of Ambulance and House Surgeon of the Cumberland Street Hospital of Brooklyn for the years 1899 and 1900. In 1900 he returned to California, practicing in Sacramento during 1901-1903. From January, 1904, until March 21, 1909, he was Assistant Emergency Surgeon in San Francisco, when he became Chief Surgeon of the San Francisco Emergency Hospitals, serving until March 1, 1910. He was appointed Secretary-Treasurer of the California State Board of Medical Examiners in February, 1913, holding that position until February, 1943, thus completing thirty years of service to the State. In 1930 he was elected President of the Federation of Medical Examining Boards of the United States.

During his years of service as Executive Officer of the California Board of Medical Examiners he was instrumental in putting out of existence the so-called "Men's Specialists" with their wax-works museums, etc. He worked tirelessly to stamp out a group of alleged swindlers known as the "Eyesight Swindlers." This group was national in scope and preyed on the blind and aged to the extent of millions of dollars. He was active in numerous reforms affecting the spread of the narcotic evil, and aided greatly in putting an effective stop to the so-called Pacific Coast Abortion Ring. During his years with the Board of Medical Examiners, California attained a high standard among Medical Examining Boards of the United States.

Dr. Pinkham retired from State service in February, 1943, taking up his home in Atherton, where his death occurred on July 14, 1944.

* * *

This generation has learned all over again that there are great differences between a social order that is fundamentally bad and one that is essentially good.—Harry Woodburn Chase.

* * *

Of the approximately 132 million persons in the United States, 13 million live in New York State, 11 million of them in urban areas, including over 7 million in New York City.

CALIFORNIA PHYSICIANS' SERVICE[†]

Board of Trustees

Ray Lyman Wilbur, M.D., President, Stanford University
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Chester L. Cooley, M.D., Treasurer, San Francisco
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C. Glenn Curtis, M.D., Brea
P. K. Gilman, M.D., San Francisco
H. Randall Madeley, M.D., Vallejo
A. E. Moore, M.D., San Diego
Rt. Rev. Thos. J. O'Dwyer, Los Angeles

The *new Board of Trustees of C.P.S.* had its first meeting on Sunday, June 11th. As was expected, the highlights of the meeting were directly related to the actions of the Council of C.M.A. and the House of Delegates of the C.M.A., who also acted as Administrative Members of C.P.S.

The *report of the public relations firm, Foote, Cone and Belding,* was given and certain recommendations were made. Those subsequently had been considered by the Executive Committee of the Council of the California Medical Association, and two of their members, Dr. John W. Cline and Dr. Karl L. Schaupp, appeared before the board of C.P.S. to acquaint them with their resolution regarding this report. The substance of the resolution was that C.P.S. consider the employment of a highly competent over-all executive. There was a great deal of discussion on this, because of the administrative implications and relations between C.P.S. and the C.M.A. The matter was handled by appointing a committee to investigate possible candidates.

The next order of business was the approval of *unit values* for March and April at $2.25, with a surplus of $1,000 going to the unit stabilization fund.

The *report of the Certified Public Accountants* for the financial operations of the fiscal year was presented to the Board, and showed that C.P.S. did business in the amount of $1,340,315—an increase of one-half million dollars over the previous year. The unit value steadily increased during the year, until it has reached almost par value, at the same time transferring over $60,000 to the unit stabilization fund. This has been accomplished in the face of increasing wage levels and the general chaotic state of employment. This increase in administrative costs and personnel problems will probably continue to be an important factor in this coming year.

Several *new organizational* changes were made, the most significant one being the appointment of a new Executive Committee. Because of travel difficulties, the Executive Committee, which is designed to give adequate representation to the North and South, had never functioned to the complete satisfaction of the board. A new Committee, composed of Dr. T. Henshaw Kelly (chairman), Dr. Glenn Myers, Dr. A. E. Larsen, Msgr. Thomas J. O'Dwyer and Dr. C. L. Mulfinger, was appointed. In order to insure its effectiveness, the North and South sections will meet on the same dates, handy to telephone connections, which would allow all of the members of the Executive Committee to discuss over the telephone any subject that requires the decision of the entire Committee.

[†] Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

In the matter of *progress reports*, in addition to the commercial program, which we have described above, the Housing Program was discussed. It was pointed out that the Marin Housing Project is the most stable, whereas in the *Vallejo* Area and the *Harbor Area of Los Angeles*, there were current problems relating to enrollment of the families in those areas. In *Richmond*, C.P.S. has undertaken, at the request of Procurement and Assignment Service and on capital advanced by the California Medical Association, an emergency program to relieve the Richmond physicians.

The *Rural Health Program* was described as in a "disintegrating state," due to the fact that the incomes of farmers have rapidly increased during the past year, so that they are no longer applying for F.S.A. loans, and therefore their membership through F.S.A. was not being continued.

Acquisition activities were discussed, and it was pointed out that not over a year ago, our rate of growth had been about 1,000 new members per month, while at the present time we are averaging around 6,000 members per month. However, it was pointed out that due to the large turn-over in employment, the net gain in membership would only be 30 to 50 per cent of the new members enrolled. Some of the obstacles to achieving large volume, as recommended by the Little Report, were discussed. Some of the limitations imposed on C.P.S., such as the income ceiling and the lack of whole-hearted coöperation of the medical profession, are matters of first importance that will hinder rapid growth.

An administrative change of major importance was also accomplished at the June meeting, in that Mr. Ebersole, who was formerly Acquisition Manager for Southern California, was released to the California Medical Association to carry on their public relations program. Mr. William Bowman, who had previously been the Acquisition Manager for the North, was appointed an Assistant Director to represent C.P.S. in the South. He was also made a member of the Acquisition Committee, to work with the Hospital Service of Southern California, which is represented by Mr. Ralph Walker. This move has long been necessary to strengthen the administrative set-up in the Southern Area.

T. Henshaw Kelly, M.D.,
Secretary.

Hospitalization Insurance in 1754: "Nothing New Under the Sun"

Not so long ago your Observer discussed at length various phases of medical care with a physician who was well informed on the subject. Among other things "plans" for providing health services were mentioned. The doctor said, "Of course, you know there is really nothing new about hospitalization insurance. If you will read the *Bulletin of the New York Academy of Medicine* for February, 1944 you will learn that in the eighteenth century a far-sighted Frenchman proposed a plan which at that time was thought too visionary to be taken seriously." Your Observer obtained a copy of the *Bulletin*, read the "story" and thereupon decided that readers of his column would find it both interesting and enlightening.

A description of the plan is preceded by a brief biographical sketch of Piarron de Chamousset, who conceived the insurance scheme. Chamousset, the son of a distinguished and wealthy family, was born in 1717. He dedicated his life to reforms and public welfare and worked passionately and zealously for their consummation. His experience with a hospitalization insurance plan has a familiar ring even in these times. One must remember, however, that the conditions existing in hospitals of that period were pretty terrible, and the proposal of an insurance scheme "must have seemed pure fantasy at the time of its publication."

It is not possible to publish in full the description of the scheme, which was entitled a "Plan of a Hospital Association in Which by Means of a Very Modest Sum Each Member Will Be Assured in Case of Sickness of Any Kind of Assistance Which He May Desire." However, selected paragraphs should be sufficient to give to those who are interested in this subject an adequate idea of Chamousset's proposals.

The objectives of the plan were described as follows:

"It is then of interest to all citizens to form an establishment which furnishes all the necessary aid to the sick, and which guards against all the inconveniences of which we are about to speak. For this it is necessary (1) that the rich be received in a manner which leaves nothing to be desired, even to their niceties; (2) that the treatment in sickness be absolutely the same both for them and for those less fortunate; (3) that the expense be suited to the means of those in the hardest circumstances; (4) finally that propriety hinders no one from profiting from the aid offered them. Such is the principal object of this establishment which we propose to the public, and it will be executed by a free association which will continue only as each member finds it to his advantage, and by which one may acquire by paying each month a most modest sum the right to procure all the aid one might need in case of illness either at home or in a hospital, of which one becomes co-proprietor by joining this association."

As to the service which would be offered, the following gives the reader a good idea:

"A complete pharmacy will be established there, provided with excellent drugs and managed by most intelligent men. Physicians and surgeons in chief will be assembled, selected with all possible care, who will be attracted equally by the honor of filling such positions and by the salaries attached to them. Other physicians and surgeons of sufficient number and living also at the hospital will work assiduously under the eyes of their chiefs, healing the sick, some prescribing, others dressing the wounds of those who have undergone operations. A fixed number of young physicians will be received, lodged and fed, for a modest fee, who doubtless will be eager to train there and who will at the same time be of great help at the bedside of the sick, reporting to the physicians the effects of their prescriptions and an infinity of enlightening observations to render the treatment more certain.

"Two of the most celebrated physicians of Paris will come regularly every day to consult with those who live in the establishment and decide together the puzzling cases which demand mature deliberation. If it happens that a patient has confidence in a physician or surgeon who is not connected with the hospital, he will be free to associate himself at his expense with the other physicians and surgeons of the hospital.

"In order to prevent mistakes and to keep the condition of the patients always under the eyes of the physician as well as the symptoms which he has noticed, all prescriptions will be written, also the regimen, and placed at the patients' bedsides. Furthermore, it will be a new means of study and observation for young physicians, not counting the fact that this way of writing prescriptions will make the physicians more attentive in composing them.

"Surgery will be cultivated with no less care, and there will be added to the number of surgeons, aides and boys admitted and boarded in the hospital, other pupils paying also a very modest sum for their food and lodging. These will be trained under the eyes of the masters and will be inspired by the hope and desire of winning in the competition, the only way by which any of the positions in the hospital may be obtained. Add to that vigilant care and surveillance, a scrupulous choice of the proper foods, and every attention to cleanliness to prevent disgust and to avoid unpleasant atmosphere. Such are the principal precautions to be taken for the treatment of patients and the care of diseases in general."

In connection with the administration of the plan Chamousset said,

> "The Hospital will be governed by an administrative body, sufficiently large, elected every three years, but no one can be elected except members."
>
> "None will have the right to the assistance of this hospital except those who have been admitted to membership, and in order to allow for different conditions and means, there will be established five classes of members who will pay more or less, not for teatment of their diseases (for all classes will receive the same care), but for optional accommodations which vary according to conditions and which are necessary only to those who habitually enjoy them.
>
> "Each member of the first class will occupy a complete apartment and will be furnished and served in a manner suitable to his way of life. Those of the second class will each have a separate room; those of the third will be in rooms containing two or three beds; the fourth will be assigned to halls with a dozen beds; and the fifth in halls with thirty beds in which the patients will never be side by side, as each of the beds will be enclosed by a partition which will form a little room."
>
> "Here is the table of the different prices which members will pay according to their age and class. You will notice that only those between fifteen and sixty may join. But the membership fee never changes for those who are punctual about continuing their membership; it remains just what it was when they started, and their membership has no other termination than that of their life. Heads of families should receive an advantage over others, that of paying the price fixed for the class between 15 and 35 years for each member of the family rather than paying per person according to age.
>
> "[The abbreviations in the following table refer to *sol,* half penny, and *livre,* franc.]

Members will pay by month—	*Rooms with 30 beds*	*Rooms with 12 beds*	*Rooms with 3 beds*	*Rooms with 1 bed*	*Apartments*
From 15 to 35 years of age	25s.	30s.	40s	3 1.	5 1.
From 35 to 40 years of age	26	32	43	3 4s.	5 8s.
From 40 to 45 years of age	27	34	46	3 8	5 16
From 45 to 50 years of age	28	36	49	3 12	6 4
From 50 to 55 years of age	29	38	52	3 16	6 12
From 55 to 60 years of age	30	40	55	4	7

These are just a few of the provisions in the plan described by Chamousset. Their resemblance to those incorporated in modern-day plans is striking, which simply goes to prove that "there is nothing new under the sun."

Free Enterprise—The American Heritage

Mr. James Mussatti, General Manager, California State Chamber of Commerce, in a recent publication, stated:

More than a decade ago the California State Chamber of Commerce, speaking for its broadly representative membership, adopted a basic policy asserting its faith in the free private enterprise system. This policy expressed the State Chamber's intention to work unremittingly for protection of this fundamental American principle, and for preservation of the rights of the individual under the Constitution.

At a meeting of our Board of Directors held in December of last year this basic policy was reviewed and reaffirmed by our Board. In my opinion this policy, which is so stated that it covers any form of encroachment on the free enterprise system, is worthy of quoting in full. It is as follows:

"The very essence of civilization is that there be placed upon the individual only that degree of restraint which shall prevent his encroachment upon the rights of others, thus releasing to the utmost, individual initiative in every proper direction. Our form of government most effectively expresses and maintains this principle. Within our basic law exists ample provision for such changes as may from time to time be necessary to safeguard our people. It is therefore essential that our government should scrupulously refrain from any activity in business or industry when it can be successfully undertaken and conducted by private enterprise. Any tendency of government to enter such fields should be carefully weighed in the light of its possible effect on the very genius of our institutions."

Another phase of the problem was recognized by our Board of Directors in 1938 when the steady encroachment of Federal bureaucratic control over all elements of production and distribution reached a point where it became necessary for "agriculture and industry to declare themselves positively and unequivocally in favor of maintaining the system of free enterprise constituting the very foundation of our economic life, or indicate willingness to accept a condition of state socialism."

The State Chamber of Commerce, therefore, in recognition of this increasing danger, urged all local, statewide, and national organizations, and their individual members to put forth their utmost effort in opposition to any and all tendencies toward the undermining and throttling of the American system of free enterprise, "to the end that American prosperity may be restored and maintained."

Acting under these basic principles the State Chamber, in March of 1939, specifically opposed a group of bills then pending before the State Legislature providing for a system of compulsory state health insurance. Subsequently in May of the year, the Board took cognizance of the fact that the problem of proper medical care for lower income groups did exist and should be faced; but strongly recommended that existing voluntary plans be given opportunity for trial and that factual information be made available for all interested groups in order that an equitable solution may be reached. The Chamber's position opposing pending health insurance legislation was reiterated.

This same principle motivates the State Chamber's opposition to the Wagner-Murray-Dingell Bill—the "cradle to the grave" social security measure which would socialize American medicine and increase all existing social security benefits at the expense of tax-paying employers and workers. The State Chamber's statewide Social Security Committe has pointed out that if this measure were passed, *it would endanger the present high standards of medical care and science which have been achieved primarily because of the enterprise of American medical and allied professions.*

Other forms of encroachment upon the principles of free private enterprise have been vigorously opposed by the State Chamber. The Chamber opposed construction activities on the part of governmental agencies which could be carried out by private enterprise. It has consistently resisted attempts by the Federal Government to regulate and control natural resources of the states, and has advocated that these resources be kept under state control. . . .

Currently the State Chamber is opposing Federal legislation which would mobilize all scientific and technical resources of the nation under Federal control. This legislation would, in effect, assign to one governmental office the power to shape and make the trend of productive enterprise in the United States.

The battle against socialization of industry, agriculture, medicine, and other phases of our economy must be fought on two fronts. We must meet the direct attack against the private enterprise system through legislative enactment and we must oppose with all our strength the insidious encroachment of Federal bureaucracy into purely state and local affairs.

If we are to preserve our American system of free individual enterprise we must, ourselves, meet the problems which arise in our state, our counties, our cities,

(Concluded on Page 77)

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session will be held in New York City.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note. For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In August, KFAC will present these broadcasts on the following Saturdays: August 5, 12, 19, and 26.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Departments of the United States Army and the United States Navy, are on the air each Saturday at 1:30 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians*:

1. *It Is Said:* By Arno Luckhardt that Univ. Chicago Press's symposium on *Medicine and the War* is excellent. It is. That R. West's *Conscience and Society: A Study of the Psychological Prerequisites of Law and Order* (Methuen, London, 1943), is worth reading. It is. That K. J. W. Craik's *The Nature of Explanation* (Cambridge Univ. Press, 1943), is worth study. It is. That *Advances in Enzymology*, Vol. 4 (edited by F. F. Nord and C. H. Workman, Interscience Publishers, N. Y., 1944), is worth ordering. It is. That M. B. Jacobs well edited *The Chemistry and Technology of Food and Food Products* (2 vols. at $19.00, Interscience Publishers, N. Y., 1944). He did. That Otto Glasser deserves much congratulation, with his collaborators, for compiling the encyclopedic *Medical Physics* (1 vol. at $19.00, Year Book Publishers, Chicago, 1944). He does.

2. *Have you seen:* Sir Thomas Lewis's reflections on reform in medical education (*Lancet*, May 13, 20 and 27, 1944)? H. E. Sigerist's comments on the University at the cross-roads (*Bull. Hist. Med.*, 15:233, 1944)? Alan Gregg's question, "Can excellence be learned? (*Jour. Asso. Amer. Med. Coll.*, 19:105, 1944)? The provocative report of the Baruch Committee on Physical Medicine (597 Madison Ave., N. Y., 1944)? M. Meuburger's survey of the concept of nature from a medical standpoint (*Isis*, 99:16, 1944)? C. J. Herrick's discussion of the incentives of science (*Sci. Month.*, 58:462, 1944)? And Alan Gregg's further philosophical critique of medical research (*Sci. Month.*, 58:365, 1944)? If not—better take a look.

3. *Control of Air-borne Bacteria:* Conclusive evidence comes from A. P. Krueger and Co. (*Naval Med. Bull.*, 42:1288, 1944), that glycol sprays are not as effective as proper floor oiling in controlling droplet-dust infection spread in hospitals or public places. Wholly independent confirmation comes from three British groups, J. Wright & Co., F. C. Harwood & Co., and P. H. R. Anderson and Co. (*Brit. Med. J.* 1:611, 615, and 616, May 6, 1944), that oiling floors and bed clothes controls dust borne infections in hospitals and public places. No wonder K. F. Meyer jumped me for recommending glycols!

4. *British Medical Bulletin:* Published by British Council, Medical Dept., 3 Hanover St., London, W1, goes to town again with special number on drugs (Vol. 2, 1944). F. H. K. Green discusses clinical evaluation of new remedies (p. 58). W. Yorke reports on aromatic diamidines in protozoal infections (p. 60). F. Hawking summarizes recent work on the pharmacology of sulphonamides (p. 70), and surveys biological standardization of neoarsphenamine (p. 70). The Faraday Society symposium on modes of drug action is fully abstracted, as are antimalarials, new synthetics and local reactions in routes of administration.

5. *Of interest:* J. F. Rinehart's cautious note on treating rheumatic fever with crude hesperidin (vitamin P), may be something (*California's Health*, 1:22, May 31, 1944). I. I. Kaplan's cautious note on treating cancer

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

with avidin (egg white), also may be something (*Amer. J. Med. Sci.*, 207:733; 1944). R. B. Roth notes surprising incidence of trichomonad infection of male genital tract (*VD Info.*, 25:163, 1944). J. S. K. Boyd and B. Portnoy show conclusively that bacteriophage has no action *in vivo* comparable to what it has *in vitro* in bacillary dysentery (*Trans. Roy. Soc. Trop. Med. Hyg.*, 37:243, 1944). J. C. Aub reviews physiologic aspects of traumatic shock (*J. Indust. Hyg. Tox.*, 26:183, 1944). W. and G. Henle find that influenza virus inactivated by ultra-violet or 56° C. interferes with growth of active influenza virus (*Amer. J. Med. Sci.*, 207:705, 717, 1944). S. Sunderland calls attention to deceptive muscle action in peripheral nerve lesions (*Austral. N. Zea. J. Surg.*, 13:160, 1944). W. D. Paul and C. R. Kemp show that methemoglobin averages 0.1 per cent in normal humans (*Proc. Soc. Exp. Biol. Med.*, 56:55, 1944).

C.M.A. Public Opinion Survey.—The article by John R. Little on "Public Opinion Concerning Medical Practice in California," which appeared in CALIFORNIA AND WESTERN MEDICINE for May, 1944, on page 241, is receiving considerable notice in other medical journals.

In *Current Medicine* for July-August, six pages are given to excerpts from Mr. Little's report, and a similar amount of space is allocated in *Medical Economics* for July. Comment is also made in some of the state medical journals.

It is evident, therefore, that the report in the May number and also the report which appears in this current issue as the opening article, is being given wide publicity, and the factual and other information will receive much consideration by physicians who are interested in modern-day medical trends.

Donation to U. C. Department of Tropical Medicine.—A donation by the Columbia Foundation of San Francisco of $13,800 to assist in the establishment of a department of tropical medicine at the University of California Medical School in San Francisco has been revealed by Robert G. Sproul, president of the University of California.

Total gifts to the University last month amounted to $45,000.—Hollywood *Citizen-News*, June 28.

Resident Vacancy Available in Santa Clara County Hospital.—A Residency in the Department of Tuberculosis and Chest Diseases will be available in the Santa Clara County Hospital on October 1, 1944.

The institution has a bed capacity of 456, which includes 105 beds for tuberculosis. In addition, there is a large outpatient department.

Further information may be secured by addressing C. G. Scarborough, M.D., Santa Clara County Hospital, Los Gatos Road, San Jose.

Clark Gable Is Sought For "Kaiser Wakes the Doctors."—One of the most startling medical books of years is "Kaiser Wakes the Doctors." It succeeded in getting its author, Paul De Kruif, in the center of a storm with the American Medical Association. I have no intention of putting myself in the middle of this battle, pro or con, but news is news. After seven months of negotiations, Edward A. Golden who made "Hitler's Children" and "The Master Race," has purchased the De Kruif book and his son, Robert Golden, will produce it in technicolor.

The Goldens, father and son, feel they have such a big property in the controversial story they hope to bait such a big catch as Clark Gable for the starring rôle. Of course, that means he would have to be borrowed from his home lot, M.-G.-M., and I have a hunch Metro will keep their top star at home no matter how attractive other offers may be.—Louella O. Parsons, in International News Service—Fresno *Bee*, July 17.

International College of Surgeons Meeting.—The program at the Ninth Annual Assembly of the United States Chapter of the International College of Surgeons will be devoted to War, Rehabilitation and Civilian Surgery. The sessions will be held at the Benjamin Franklin Hotel in the City of Philadelphia, October 3, 4, 5, 1944.

Special arrangements have been made with hotels in Philadelphia to take care of visitors coming from distances. Information may be secured from Dr. Benjamin Shuster, Philadelphia, Pa.

The medical profession is invited to attend the Assembly and its sessions.

President American Proctologic Society.—Wm. H. Daniel, M.D., chairman of the Board of Trustees of the Los Angeles County Medical Association, was elected president of the American Proctologic Society at the annual meeting of that organization in June. Dr. Daniel had served as secretary of the society for four years. The American Proctologic Society was organized in 1899.

Henry Kaiser and Medical Clinic Centers.—Under the caption "Millions Dropped in Mr. Kaiser's Lap!", a special feature article concerning a copartnership in the Standard Gypsum Company, appeared in the San Francisco *News* of July 25th. The following paragraph is an excerpt from the article:

"The Kaiser post-war job scheme was revealed as taking five main directions: Housing, highways, shipbuilding, *medical clinic centers*, transportation. He said he expected hundreds of thousands of jobs to be created in those fields."

California Population is 8,450,000—Up 1,500,000 Since 1940.—The State Reconstruction and Reëmployment Commission on July 25th, placed California's population at the beginning of 1944 at 8,450,000 and predicted the State's population by 1950 will be anywhere from 8,500,000 to 9,450,000 persons, depending on post-war conditions.

From April of 1940, to January of 1944, said the State's postwar commission, California's population increased more than 1,500,000, the greatest numerical increase of any State for this period.

This growth was due to an influx of 1,320,000 migrants and to 537,000 births, placing California in third place among the States in population, passing Ohio and Illinois to be exceeded only by New York and Pennsylvania.

Also stressed was the increase in the number of families during this period, rising from 2,146,809 to 2,700,000 families, an increase of 25.8 per cent compared with the national family increase of only 4.6 per cent.

More than three-fourths of the population increase has come in San Diego, Los Angeles County, and the San Francisco Bay region, and during the peak of migration between April, 1943, and January of 1944, the newcomers averaged 42,400 per month.—San Francisco *Examiner*, July 26.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Medicine

The increased socialization of medicine that Dr. Parran of the United States Public Health Service foresees after the war seems a reasonable certainty. The issue of importance to both medical profession and the public is whether it shall be directed and controlled by expert and ethical medical organization, or by politicians whose chief enthusiasm is socialization of everything. It would be a great relief if an organization like the American Medical Association, in which the people have confidence, would step into the breach with constructive action to meet the reasonable requirements for public health.—San Francisco *Chronicle,* July 14.

Parran Backs "Socialization" in Medicine

Washington, July 12.—(UP.)—Dr. Thomas Parran, Surgeon General, U. S. Public Health Service, said today that "too much heat and not enough light" has been turned on socialized medicine, and he predicted that more, not less, socialization of medical facilities would be needed for a $1,989,000,000 public health program he advocated.

He told a Senate subcommittee on war-time health and education that "sound health is as necessary for the tasks of peace as the tasks of war" and added:

"It is my belief that we can have a national health program fitted to the Nation's needs and the social and economic problems of the 48 States not entirely with socialized medicine but not with more private medical practice than we now have."

Plan Outlined

He outlined a plan for 417,000 hospital beds and 2,400 health centers and sub-centers, costing $1,989,000,000, not including the health needs of veterans, which he said the Nation must place on a sound basis.

"As our knowledge increases," he said, "the need grows for putting this complex science (research, diagnosis and treatment) to the service of the people by groups of trained persons working as a team. The day of the country doctor of the saddle bags is past."

Parran advocated an integrated system of public health service beginning with health centers in every community feeding general and specialized hospitals. He said that prepaid insurance plans of the Blue Cross, strongly advocated to the committee by Dr. Claude W. Munger of the American Hospital Association Council on Government Relations, "does not seem applicable to the large low income groups" which constitute the "major financial burden on Voluntary hospitals."

The 4Fs of the next war can be picked out from school records of the present children. Parran said on the basis of a study made at Hagerstown, Md.

Selective service records of rejectees in this war were compared with public school health records of the rejectees 15 years before. He said 96½ per cent of the men rejected for teeth defects had teeth defects when they were examined in the public schools. Similar high percentages prevailed in other causes for rejection.—San Francisco *Chronicle,* July 13.

Cream of Tartar Found Aid to Surgery

St. Louis, June 24.—(AP.)—Cream of tartar has come out of the kitchen and into the operating room to save human lives.

Dr. M. G. Seelig, a St. Louis surgeon, explained his discovery recently in the *Journal of the American Medical Association.* Cream of tartar can replace talcum powder as a dusting agent for surgeons' gloves.

For, Dr. Seelig, reported, talc causes many kinds of complications after operations—adhesions, abdominal obstructions, peritonitis. Frequently, additional operations are needed because talc fragments sowed seeds of complications in the operating field, as they fell from the surgeon's rubber gloves. . . .

Dr. Seelig and his assistants experimented with about 50 substitutes. He described the dusting agent they were seeking, one that wouldn't dissolve when gloves are sterilized under intense heat, one that wouldn't leave particles in incisions.

France a Main Source

They tried chalk because it's been used harmlessly in women's face powder for so many years. But it caused adhesions in experimental animals. And they tried starches—but starch dissolved under intense heat.

Cream of tartar was the answer.

Tartar is not yet in general use as a dusting agent, Dr. Seelig said. Doctors have large supplies of talc on hand. Also, one of the main sources of cream of tartar is unavailable on account of the war—the wine centers of France. For tartar comes from wine deposits.

"It's true, also," Dr. Seelig explained, "that tartar shortens the life of rubber gloves. But a pair of rubber gloves costs about 25 cents. Using tartar increases the cost about 12 cents.

"Operations can cost thousands of dollars—and human lives."—Hollywood *Citizen-News,* June 24.

Can Do

Sometimes miracles are requested of the Sea Bees on isolated islands in the South Pacific.

The following is an example of the spirit of "Can Do."

The medical department of a construction battalion, finding itself without a thermal cautery requested the electrical department to make one. With the usual promptness that goes with their "Can Do" attitude, a thermal cautery was presented a few days later.

It is interesting to note how ingeniously the material for the cautery was procured.

The transformer, from combined covers of two burned out Radar transformers wound with scrap wire. The heat control unit was made up of carbon lighting arrestors. An old electric iron provided the mica. The plastic heat regulator was made from an antiseptic bottle. Eleven flexible wires twisted together and taped made up the cable. The handles came from a welding rod insulated with bakalite from an old tester. A wrecked bomber provided the control switch and the cautery wire. Finally the meter from an old generator and the screws from an old field telephone.

There are very few problems of construction that the combined knowledge of a Sea Bee battalion can not solve. The originality of any one finished product is quickly disowned by any one individual and the usual answer is, "We all got together on it."

Such a spirit of integration, willingness and "Can Do" will in the end spell defeat for the enemy.—*Detroit Medical News,* July 10.

San Francisco Health Department Doctors Rap Gonorrhea Treatment as Not Thorough

San Francisco, July 13.—This country is losing an opportunity to deliver a terrific blow against gonorrhea, because, two health officials asserted today, some army, navy and civilan doctors are discharging patients as cured even though they still are capable of infecting others.

The statement was made by Dr. J. C. Geiger, San Francisco health director, and Dr. Richard A. Koch, head of the municipal venereal disease clinic, in a special report on gonorrhea carriers. The clinic handles hundreds of cases each month, treating and testing servicemen and women as well as civilians.

One-Third Still Infected

Geiger, Koch and the late Dr. Earl N. Mathis demonstrated several months ago the existence of gonorrhea carriers. They found that, about one-third of a large group of patients who had been treated with sulfa drugs and discharged as cured were still able to transmit the disease.

The health officers said this was due partly to instructions from the army surgeon general's office permitting the release of many soldiers from medical care as soon as they cease to show outward signs of the disease, and partly to similar practices by navy and civilian doctors.

"Few Infections"

The surgeon general's office explained that releases of this kind are permitted only in uncomplicated cases which clear up quickly, adding that there were "very few" instances in which soldiers thus treated had caused infections in other persons.

Nevertheless, Geiger and Koch contended that the disappearance of outward symptoms cannot be obtained unless all patients are kept under observation until shown to be disease free by three standard laboratory tests spaced one week apart.—Sacramento *Bee,* July 13.

Socialized Medicine Will Follow Advances, Clendening Predicts

Presenting the theory that medical science continues to advance steadily and thus offers new, limitless possibilities for the individual, and that 90 per cent of human beings cannot afford what science can give them today because skills and equipment are expensive, Dr. Logan Clendening, author of books on medicine and well-known, syndicated writer on medicine, predicted the coming of socialized medicine in an interview Tuesday at his summer home, 330 Lilac Drive, Santa Barbara.

Dr. and Mrs. Clendening arrived last week from Kansas City, Mo., where he is a professor of clinical medicine and medical history in the medical school of the University of Kansas. This year he introduced a new course in "Logic Applied to Medicine," which is the first time such a subject has been given by any medical school faculty in the country. Most of the medical student body at the University of Kansas are military personnel undergoing the new, stepped-up program of study.

"The medical profession does not sell a luxury-commodity, but a necessity that a civilized democracy will not permit people to do without," said Dr. Clendening. Asked if the medical profession would improve its members own economic standards through socialized medicine, he replied, "Doctors will benefit financially by socialized medicine through governmental control because it will not prevent them from practicing privately any more than public schools preclude private teaching."—Santa Barbara *News-Press,* June 21.

National Health Program Urged

The President and the Secretary of the Medical Society of the District of Columbia were among those invited to a meeting of the Council on Medical Service and Public Relations of the American Medical Association at the Mayflower Hotel, Washington, on May 22. They, like other guests of the Council, were asked to present their views on the medical situation.

Speaking for the District Society, President Sanderson said:

"It is our feeling that the American Medical Association, splendid though its record has been, is looked upon by many people with whom we speak in Washington as an 'anti' group. In other words, that the Association is seldom *for* but usually *against* any new proposal. Of course, we know that it is not the wish of organized medicine to appear in this light, nor has its opposition been due to selfish motives as is frequently charged by many persons unsympathetic, if not antagonistic, to the A.M.A. The fact remains, however, that many people here who should be our friends are not. Somehow we must win their support.

"It is imperative in our opinion that the A.M.A. present to the country its conception of a national health program. It has been said a number of times by officials of the Association that no health program can be devised which is adaptable to all communities. This is undoubtedly true but it is equally true that the underlying principles of all health programs are the same. It is our conviction therefore that the A.M.A. is obligated to actively encourage and assist state and county medical societies in the development and operation of adequate, inclusive health programs.

"Our impression is that the Association takes the position that it should keep hands off state and county society affairs. As regards a number of matters this is proper, but where a problem of such scope as the health of the Nation is concerned, it is not desirable.

"We feel that the House of Delegates might well entrust to this Council the development of a national health program. The program of itself need not be startlingly new but it should be forward-looking. Such a move would place the Association before the country in a positive rôle rather than a negative one."—*Medical Annals of the District of Columbia.*

Michigan Medical Service

The most successful experiment in prepaid medicine sponsored by a medical organization, the Michigan Medical Service, according to recent reports, is for the first time "in the black." The Service has a turbulent history. At one time its existence was seriously threatened because of financial difficulties. The Commissioner of Insurance of Michigan debated whether or not to close the Service. Interestingly enough, labor leaders intervened and urged that it be permitted to continue operation, being confident of its eventual success.

In the midst of its diffiiculties, Mr. Jay C. Ketchum was appointed Director. He and his able assistants battled against heavy odds to place the Service on a sound basis. Faced with a deficit of several hundred thousand dollars only two years ago, the financial recovery of the Service is a tribute to the executive ability of Mr. Ketchum, who is a most realistic individual. He has no illusions about the job ahead. He readily admits there are many difficult problems to be solved. He foresees in particular several knotty ones in the postwar era. Nevertheless he is confident that they can be satisfactorily met.

There is no easy road to the successful operation of a medical service plan. To begin with, it is, as Mr. Ketchum says, a selling job. People are not demanding the protection such a plan affords. However, there is a need for it and so potential subscribers must be "sold." Difficult though this is, Mr. Ketchum has found it the least of his worries.

A majority of the physicians in Michigan have been coöperative. There are a substantial minority who are not. They are the ones who have read little about the Service, know little about its operation, and are not particularly interested in it. This group is a matter of concern and much effort has been put forth "educating" them.

The Committee on Medical Care of our Society has, through its Chairman and Secretary, learned a great deal from the Michigan experiment. It should make the road easier in Washington.—*Medical Annals of District of Columbia.*

A "Safe and Sane" Fourth of July

On the Fourth of July, 1943, for the first time since statistics began to be recorded, there was not one death in the United States from fireworks. Firewater instead of fireworks got in its work and there were some 300 deaths from traffic accidents and the usual holiday quota of drownings.

But the fireworks is something to celebrate. . . . It shows once more that the world does move, no matter how slowly. . . .

The propaganda which resulted in the 1943 record has been of two kinds. One was the campaign of the American Medical Association against tetanus, or lockjaw, as a result of Fourth of July injuries and the other was against the use of fireworks at all. . . .

Here is the result of this project of public education:

In 1903 there were 4,449 injuries and 406 deaths from tetanus.

In 1904 there were 4,169 injuries and 87 deaths from tetanus.

There was not much change in the record until 1909 when there was a jump to 5,307 injuries and 125 deaths from tetanus. This ghastly toll stimulated both the anti-tetanus and anti-fireworks campaigns so that:

In 1914 there were 1,506 injuries and 3 deaths from tetanus.

Since then the improvement has been steady until, as recorded in the opening sentence of this article, we have in 1943 no deaths from fireworks injuries either caused by tetanus or otherwise.

Of course part of this good result so far as tetanus is concerned is due to the disappearance of the horse from our streets.

Still a very recent study of the occurrence of tetanus spores on the streets and pavements of Baltimore showed that 17 per cent of the cultures were positive. And no fair-minded person with a memory as long as mine of the glorious Fourths of the gay nineties down to the recent past can deny that the good results of last year are largely due to the "safe and sane Fourth" slogan. . . .
—Logan Clendening, M.D., in Berkeley *Gazette,* July 3.

Progress in Saving Lives from Tropical Diseases

It will be welcome news to hundreds of thousands of fathers and mothers whose sons are in service in tropical countries to read the statement of Rear Admiral Luther Sheldon, Jr., assistant chief of the navy bureau of medicine and surgery, to the effect that "the danger of tropical diseases for our armed forces has been overcome to a large extent." The navy medical officers feel that they "have the problem licked."

Admiral Sheldon said that he was not now at liberty to give details on the conquest of the tropical diseases, but to medical men who have heard his statement on the subject, it meant the equivalent of a major victory on the battlefield.

The progress that has been made in medicine, even during the present war, is far beyond the understanding of the average citizen who will reap the benefits. It is the result of the tireless efforts of individual doctors and institutions.—San Mateo *Times and Leader,* June 22.

A grave menace exists of another world-wide recrudescence of tuberculosis. Its prevention will require vigorous effort against the spread of infection and all measures possible to maintain a high level of resistance to disease.—Col. Esmond R. Long, MC, U.S.A.

Tuberculosis is a social problem with a medical aspect.
—Sir William Osler.

LETTERS†

Concerning Request that Health Officers Approve Special Food Allocations:

(COPY)

THE AMERICAN PUBLIC HEALTH ASSOCIATION
1790 Broadway (at 58th Street) New York 19, N. Y.

July 5, 1944.

Dr. John J. Sippy,
San Joaquin Local Health District,
Stockton, Calif.

Dear John:

I have had keen interest in reading your letter of June 29th with enclosures about the prescriptions for heavy cream.

I have forwarded the correspondence to Dr. Winslow thinking as you have that it may be grist for his editorial mill. He told me today over the telephone that he had several editorials in the works and he is the most prolific writer we have had in that position. I think you are going to like especially his editorials in the July and August issues.

Thank you for keeping us in mind in connection with this correspondence. You may be interested to know that the War Food Administration consulted us with regard to the suitability of requiring endorsement by the local health officer and that we put our heads together and replied that this was properly a function of the medical society rather than of the health officer, since it was, in the nature of the case, policing the profession. We declined to undertake a promotion among health officers of the idea that they should endorse these prescriptions.

Cordially yours,
REGINALD M. ATWATER, M.D.,
Executive Secretary.

Concerning Rounds at U. C. Hospital:

(COPY)

University of California

July 14, 1944.

Victor Johnson, M.D.,
A.M.A. Council on Medical Education,
Chicago 10, Illinois.

Dear Doctor Johnson:

Dr. George H. Kress, secretary of the California Medical Association, has requested that we supply you with copies of announcements of any recent refresher or post-graduate courses.

Because our greatly reduced staff is so very busy with the teaching of under-graduate medical students, under the accelerated program, no post-graduate work is being held at present.

We are, however, pleased to have visiting doctors, including those in the Navy and Army, attend our rounds. A notice of these is attached.

Sincerely yours,
AGNES L. TERRY, *Administrative Assistant.*

* * *

UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL

During the academic year 1944-45 (summer term, July 3 to October 21, 1944, *fall term, October 30, 1944, to February 24, 1945, and spring term, March 5 to June 23, 1945), the various divisions of the Medical School will hold rounds beginning at 9 A.M. in Toland Hall, University of California Hospital as follows:

Obstetrics and Gynecology, Tuesdays.
Medicine, Wednesdays.
Pediatrics, Thursdays.
Surgery, Fridays.

The following are also held in Toland Hall:

Tumor Clinic, Mondays—11 a.m. to 12 m.
Clinico-Pathological Conference, Wednesdays—11 a.m. to 12 m.

Concerning Public Law 216 in Re: Doctor Shortage:

In CALIFORNIA AND WESTERN MEDICINE, for June, on page 340, attention was called to Public Law 216, through which governmental aid was made available, for communities in need of physicians.

This law has now been repealed. Explanatory letter follows.

* * *

(COPY)

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE

June 30, 1944

Dr. Wilton L. Halverson,
State Director of Public Health,
San Francisco, California.

Dear Dr. Halverson:

This is to advise that the program for the relocation of physicians and dentists under Public Law 216 which became operative December 23, 1943, has been terminated by Congress, effective June 30, 1944. It will therefore be impossible to arrange any further relocations under the benefits of this program.

For those communities in your state which have contributed their share of relocation expense and for which physicians or dentists have been contracted, the arrangement will be carried out according to the terms of the contract, from funds obligated for that purpose.

Those communities which have submitted their checks for $300.00 and for which it has been impossible as yet to locate a physician or dentist, will have their monies refunded promptly.

We deeply appreciate your coöperation and assistance in this program which, in the short time it has been in operation, has effected the relocation of a number of physicians and dentists in needy areas.

Sincerely yours,
(Signed) L. R. THOMPSON,
Assistant Surgeon General.

Concerning Presiding Referees or "Hearing Officers" for California State Board of Medical Examiners and Other Licensing Boards:

(COPY)

THE JUDICIAL COUNCIL OF THE STATE OF CALIFORNIA
STATE BUILDING, SAN FRANCISCO

To Chief Justice Phil S. Gibson,
Chairman of the Judicial Council:

First Report: Committee on the Administrative Agencies Survey

This progress report is intended to give a brief summary of the work which has been undertaken and which is projected under Chapter 991 of the Statutes of 1943. That legislation directed the Judicial Council to make an investigation of administrative procedure in California and to recommend to the next Legislature a comprehensive plan suitable to the needs of this State, covering both judicial review and procedure before the agencies. For the purpose of carrying out this legislative direction, a committee was appointed to supervise the project, consisting of the undersigned members of the Judicial Council. . . .

On October 1, 1943 a conference was called at the

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* Christmas vacation, December 23 to 30, 1944.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

State Building in San Francisco by Chief Justice Phil S. Gibson, the Chairman of the Judicial Council. The purpose of this meeting was to discuss the relationship between the work which the Council was about to undertake and the work which various other bodies were doing in the field of administrative procedure. Representatives of various state boards and commissions were invited to attend, as were representatives from the State Bar of California and from the Attorney General's office. . . .

Your Committee then examined the various statutory provisions dealing with California administrative agencies, which had been summarized by the research staff. . . .

Following the preparation of this material, a public hearing was scheduled at the State Building in San Francisco for January 12, 1944. At this hearing representatives of the various medical licensing boards were invited to appear. They included: the Board of Medical Examiners; the Board of Dental Examiners; the Board of Pharmacy; the Board of Nurse Examiners; and two boards outside the Department of Professional and Vocational Standards, the Board of Chiropractic Examiners and the Board of Osteopathic Examiners. This meeting, at which your Committee acted as a hearing board, was presided over by Justice John T. Nourse and was attended by representatives of the State Bar, the Attorney General and the Department of Professional and Vocational Standards, as well as by representatives of the various boards. A list of questions, prepared by the Council's staff, furnished the basis for a detailed investigation, by question and answer, of the existing procedure of each of the boards present. This material, which was reported in a stenographic transcript, dealt with all phases of administrative procedure from the issuance of licenses to their revocation. In addition to the material already assembled, it provided your Committee with a fairly complete picture of the operation of the agencies present. In addition, each agency was asked to submit copies of all official forms used by it, and of all administrative rules which were generally available to the public.

This hearing was followed by a second held on February 3, 1944, and by a third, held on March 1, 1944. . . .

In the meantime, information has been gathered from other States in which similar work is being done. The Committee has been aided by the report of the U. S. Attorney General's Committee on Administrative Procedure, by the Benjamin Report on Administrative Adjudication in New York, by the work of the Ohio Administrative Law Commission and by suggestions from the Illinois Administrative Practice and Review Commission. . . .

Your Committee hopes to have its tentative conclusions ready for presentation to the Judicial Council early this summer. . . .

It is too early as yet to report upon the many ideas which have been discussed in connection with the Committee's work. One proposal, which has been discussed rather widely, may be mentioned. *The State Bar has approved the principle of using a so-called "hearing officer" for the purpose of aiding the various administrative boards in the conduct of their hearings.* Your Committee has asked each of the board representatives appearing before it whether, in his opinion, his particular board would favor the use of a hearing officer, trained in the conduct of quasi-judicial hearings.

Such an officer would either conduct the hearings as a non-voting chairman in the board's presence or would hold the hearing in the board's absence as a referee whose findings would be submitted to the board for decision.

While the answers to this proposal have not yet been fully tabulated, many of the boards have indicated their desire to avail themselves of the use of a trained hearing officer under some system which would not deprive the boards of the fundamental power delegated to them by the Legislature. Your Committee intends to explore this matter in more detail before reaching a conclusion with respect to it, and the same observation can be made with regard to many other thoughts expressed at the hearings held by it so far. In the meantime, however, the Committee will welcome any suggestions which may be made in connection with the problems upon which it is working.

Respectfully submitted,
JOHN T. NOURSE, *Chairman.*
C. J. GOODELL,
MAURICE T. DOOLING, JR.

Concerning Complimentary Opinions of "C. & W. M.":

(COPY)

NORTHWEST MEDICINE
Journal of the State Medical Associations
Oregon, Washington, Idaho
225 Cobb Building
Seattle, 1, Washington
July 13, 1944

Dr. George H. Kress, Editor,
San Francisco, California.

Dear Dr. Kress:

I always look over my copy of CALIFORNIA AND WESTERN MEDICINE with much interest, commonly finding something which attracts my attention. This is natural since this is one of the best state medical journals published. . . .

Sincerely yours,
(Signed) CLARENCE A. SMITH,
Editor-in-Chief.

* * *

(COPY)

RHODE ISLAND MEDICAL JOURNAL
106 Francis Street
Providence, 3, Rhode Island
July 20, 1944.

George H. Kress, M.D., Editor,
CALIFORNIA AND WESTERN MEDICINE,
San Francisco 8, California.

Dear Dr. Kress:

We will be pleased to place the San Francisco County Medical Society on our mailing list to receive the Rhode Island Medical Journal each month and in exchange we will appreciate the additional copy of CALIFORNIA AND WESTERN MEDICINE to be sent to me personally.

Your publication is kept on file here in the Medical Library and I find it one of the most interesting that we have, and therefore it will aid me greatly if I may have the additional copy for my personal records for my reference.

Sincerely yours,
(Signed) JOHN E. FARRELL, *Managing Editor.*

Desault's Bandage.—Though the fame of Desault has been overshadowed by his brilliant pupil, François Xavier Bichat, there can be no question that he was one of the most distinguished surgeons in the Europe of that day. He was a founder of topographical anatomy, and there is scarcely any other domain of surgery which he did not enrich. He did much to improve the treatment of fractures, and developed the technique of ligating blood vessels for aneurysms.—Warner's *Calendar of Medical History.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVII, No. 8, August, 1919

EXCERPTS FROM EDITORIAL NOTES

The Indemnity Defense Fund.—At the annual meeting in 1916 it was determined to establish a voluntary defense fund against claims and suits for alleged malpractice, open to all members in good standing who elected to take advantage of its terms. The initial assessment was placed at $30 and it was decided to put the plan into effect at such time as three hundred members signified their desire to avail themselves of such indemnity, and had sent in their assessments.

December 6, 1916, the three hundred checks were received and early in 1917 the council directed our general attorney to prepare the neecssary rules and regulations for the conduct and operation of the Indemnity Defense Fund. This work consumed several months, as our legal staff made a careful review and study of all phases of the matter before definitely proposing to the council a carefully worked out plan covering all the details involved. . . .

Private Enterprise and Public Health Promotion.—At this time, when the war on disease is gathering fresh allies every day, when clubs, centers and agencies are devoting earnest attention to community nursing, child welfare, better housing for working girls and countless industrial problems, when the greater need for adequate health education is being stressed by many mouths, it is interesting to review a campaign of health education which began in 1908. . . .

Splitting Insurance Fees.—A bargain requires two parties. From time to time we have attacked both of them in these columns. The effect has probably been slight. But continuous hammering may bring some improvement and, in any case, we intend to keep at it. . . .

What does all this mean? It means this:

Our Committee on Industrial Accident Insurance is now engaged in an exhaustive study of the entire situation, including the question of a fee schedule commensurate with good professional service. They will attempt to develop some relationship with the carriers whereby the latter will appreciate that good service means proper fees. Can the carriers be expected to regard such a relationship or agreement as more than a scrap of paper, if we, the party of the second part in such an agreement, have so little regard for our obligations to our own colleagues as to split fees and rebate schedules? . . .

From an Article on "The Medical Profession 'After the War'": Presidential Address by Dr. C. Van Zwalenburg, Riverside, Cal.—My talk will concern chiefly the business side of medicine, which is very much neglected. . . . When I speak of business, I do not mean dollars and cents exactly. Commercialism in medicine is degrading and has no place in legitimate practice. I mean system, organization, punctuality, management, efficiency. . . .

In California, in this year 1919, there is one physician to 394 of population as against one to 691 for the entire

(Continued in Back Advertising Section, on page 26)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.

Secretary-Treasurer

Board Proceedings

At the regular meeting of the Board of Medical Examiners held in San Francisco June 26th to 29th, 1944, 147 wrote the examination for a physician's and surgeon's certificate, 5 for a chiropodist's certificate and 2 for a drugless practitioner's certificate.

After legal hearings, the following actions were taken:

Atkinson, Archibald, M.D.—On June 29, 1944, found guilty of violation of Section 2390 of the Business and Professions Code, and placed on five years' probation without narcotic privileges;

Bird, Arthur Anson, M.D.—On June 29, 1944, found guilty of violation of Section 2391 of the Business and Professions Code, and his license was revoked;

Boudwin, Charles Bacon, M.D.—On June 28, 1944, found guilty of violation of Section 2377 of the Business and Professions Code (alleged illegal operation), and his license was revoked;

Eisengraeber, Gustav Adolf, M.D.—On June 27, 1944, found guilty, under Section 2383 of the Business and Professions Code, and his license was revoked;

Esker, George C., Jr., M. D.—On June 28, 1944, found guilty of violation of Section 2390 of the Business and Professions Code, and penalty was deferred to the August meeting of the Board;

Lundegaard, Edward M., M.D.—On June 27, 1944, found guilty of violation of Section 2392 of the Business and Professions Code (alleged aiding and abetting of unlicensed practitioner), and he was placed on probation for one year, with the proviso, that he report at the June, 1945, Board meeting;

Olberg, Frederick H. D., M. D.—On June 28, 1944, found guilty of violation of Section 2390 of the Business and Professions Code, and he was placed on probation for five years, without narcotic privileges;

Walton, George Edmund, M.D.—On June 27, 1944, found guilty of violation of Section 2392 of the Business and Professions Code (alleged aiding and abetting of unlicensed practitioner), and he was placed on probation for one year, with the proviso that he report at the June, 1945, Board meeting.

The following cases were continued to the next meeting of the Board, to be held in Los Angeles commencing August 21, 1944:

Buffum, Roy Luman, M. D.
Kunstler, Max, M. D.
Lundegaard, Edward M., M. D. (second citation).

The following case was continued to the Sacramento meeting of Board, commencing October 16, 1944:

McPheeters, George C. H., M. D.

News

"Clyde O. Turner Tuesday morning pleaded guilty to a charge of attempting to treat the sick and afflicted without a license, and was fined $100 by Justice of the Peace T. F. Lewis. Turner on Friday afternoon had pleaded not guilty to the charge and asked for a jury trial. A second charge of violating the business and professional code by using the letters 'Dr.' in an advertisement was dismissed by Judge Lewis. The charges were brought against Turner Friday by Joseph W. Williams, special agent for the State Board of Medical Examiners who stated Turner had no license to practice physical therapy and foot correction nor to treat neuritis, nervous disorders, arthritis, headaches, etc., as he advertised . . ." (Placerville *Times*, May 24, 1944.)

(Continued in Back Advertising Section, on page 42)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

"...information on nutrition or other health subjects should be obtained from the medical profession..."

WATSON, E. R.: SYMPOSIUM ON NUTRITION,
J. MED. ASSN. GEORGIA, 32:326 (Oct.) 1943

The above truism applies with particular emphasis to the early recognition and treatment of vitamin deficiency conditions.

Therefore, cooperating fully with the clinician, White Laboratories steadfastly continues to promote White's Prescription Vitamins solely to the medical profession.

White's prescription products are in *no* way advertised to the laity.

● WHITE LABORATORIES, INC.
Pharmaceutical Manufacturers, Newark 7, N. J.

White's PRESCRIPTION *vitamins*

TODAY — TOMORROW

TODAY—your debtor owes you for services, but you do not need the money and so do nothing about collecting.

TOMORROW—conditions have changed. You DO need the money and you try to collect. But "Mr. IOU" is gone—passed away, leaving no estate—moved to parts unknown—or is unemployed.

MORAL—You are wise and **MORE FAIR TO YOUR PATIENT** if you insist upon payment TODAY, and so guard against the contingencies of TOMORROW.

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Manager

PARK SANITARIUM 1500 PAGE ST.
SAN FRANCISCO

BOOK REVIEWS

(Continued from Page 22)

proprietary brand being "Sulfasuxidine"; Diodrast Concentrated Solution, a preparation of the already accepted Diodrast, for use in a special diagnostic procedure for visualization of the circulatory system and also cholangiography; a preparation of Sodium Benzoate for use as a liver function test; Mersalyl and Theophylline, accepted under the name Salyrgan-Theophylline Tablets proposed as an adjunct to intravenous injection of the already accepted drug; Zinc Insulin Crystals and Zinc Insulin Injection Crystalline; Tetanus Toxoid; and Concentrated Oleovitamin A and D, a dosage of the pharmacopoeial preparation.

A glance at the preface shows that certain general articles have been revised to bring them up to date. More or less important revisions have been made of the following chapters: Barbituric Acid Derivatives, Estrogenic Substances; Parathyroid; Ovaries; Sulfonamide Compounds; Vitamins, especially the sections, Vitamin B Complex and Vitamin D. In this connection it is worth noting that each chapter in the book is reviewed annually, or more often if indicated, by the responsible referee for such revision.

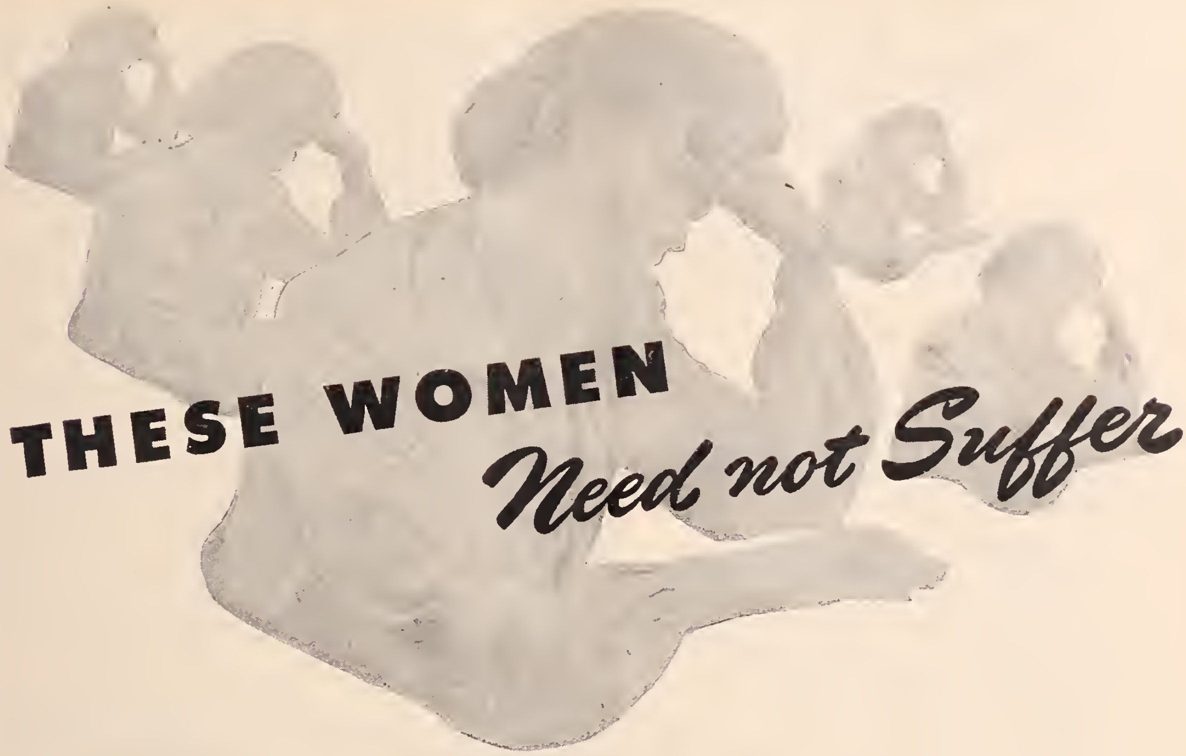
This volume is of paramount interest to all those concerned with rational and modern drug therapy.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 128)

United States, one to 1,500 in England and Wales, and one to 2,000 in Germany. (According to the census of 1910.) Our medical congestion is being rapidly increased by many men coming here direct from their army experience. In addition, we have innumerable varieties of

(Continued on Page 30)



FOR SOME WOMEN the climacteric is practically uneventful except for the cessation of menstrual function. To others the cessation of ovarian activity becomes a crisis to themselves and their families.

One of the valued contributions of endocrinology was the discovery and isolation of potent estrogens and their usefulness in alleviating the distressing symptoms of the menopause.

Within the last five years the natural estrogens have decreased in cost while orally administered diethylstilbestrol costing only one or two cents a day has brought estrogenic therapy within the reach of every woman.

The Squibb Laboratories supply the *natural* estrogens Amniotin, in a variety of dosage forms for use orally, intravaginally or by hypodermic injection. The present price of Amniotin in Oil in capsules is the lowest in history; for injection, Amniotin in Oil in the vial packages makes the cost per dose relatively inexpensive and enables the physician to vary the dosage to fit the patient's requirements.

Diethylstilbestrol Squibb is available in a like variety of dosage forms except that for oral administration it is supplied in tablets rather than capsules. Reports in the literature indicate that, where excessive dosage is avoided, many patients acquire a tolerance to the drug and are able to take it without discomfort.

For literature address the Professional Service Dept., 745 Fifth Ave., New York 22, N. Y.

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Manufacturing Chemists to the Medical Profession Since 1858

BUY AN EXTRA WAR BOND . . . — FOR VICTORY

Colfax School for the Tuberculous

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There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
4. Every proved method of treatment, including pneumothorax and phrenic nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)
5. An absence of institutional atmosphere.
6. Reasonable rates.

* * *

For further information write

ROBERT A. PEERS, M.D.
Medical Director
COLFAX, CALIFORNIA

* * *

F. LYNN SMITH, M. D.
Consultant in General Medicine

F. HARRY BENTEEN, M. D.
Consultant in General Surgery

EMILE HOLMAN, M. D.
(Stanford Hospital),
Consultant, Thoracic Surgery

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An institution owned and operated by Drs. Soiland, Costolow and Meland, dedicated to the study and treatment of cancer, neoplastic pathology and allied disease.

The Institute is provided with adequate facilities for the surgical and radiological treatment of such lesions by approved standardized methods.

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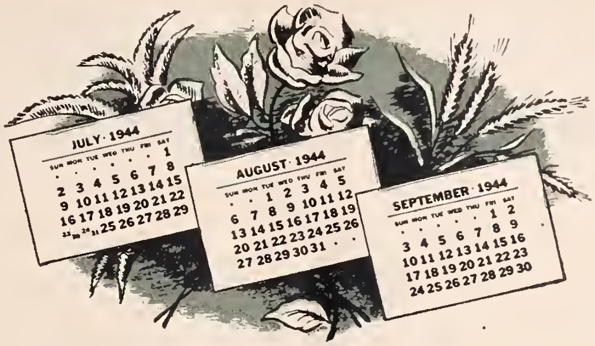
*A. H. Warner, Ph.D. R. H. Neil, A.B.

* *In Military Service*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Available in a 1/4% or 1% solution in 1-oz. bottles for dropper or spray; and as a 1/2% jelly in collapsible tube with applicator.

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INJECT 1 to 3 cc. Metrazol as a restorative in circulatory collapse and shock, respiratory distress, deep anesthesia, and in morphine and barbiturate poisoning. For circulatory stimulation in the emergencies of pneumonia and other overwhelming infections, and in congestive heart failure, give 1½ to 4½ grains Metrazol three times a day.

Ampules 1 cc. and 3 cc. (each cc. containing 1½ grains Metrazol.) Tablets 1½ grains and the soluble powder

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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

quacks, who all add to the competition for bread and butter. Verily our business interest demands that we stand together.

There are now returning nearly 40,000 physicians who have seen more or less of Army life. What new ideas do they carry? What are they going to do? A good many of them are restless; all of them would like to improve the position which they formerly held; many of them are changing locations; hundreds will come to California before they settle down. They all carry, more or less, the gospel of organization, coöperation and specialization. . . .

Organization, coöperation and specialization—these are the three prominent lessons which this war should bring home to us. The best way to carry them out is to adopt better business methods, better organization, more consultations, more community practice, more group practice, hospital standardization, and higher scientific attainments.

In conclusion, then, let us push firmly along these lines:

1. Better business methods.
2. Better organization in our societies.
3. League for Conservation of Public Health.
4. Hospital standardization.
5. Better salaries for public health officers.
6. More specialization.
7. More consultations.
8. More group medicine.
9. More publicity.
10. More science.
11. More records.
12. More brotherhood.

From an Article on "The Physician and Industry," by

(Continued on Page 40)

Basis for many uses

The pharmacologic actions of Luminal have been applied with great advantage in the clinical management of a variety of conditions and disorders . . . This well established drug exerts a sedative, hypnotic, antispasmodic and anticonvulsant effect . . . The desired result is often only a matter of dosage . . . Continued freedom from symptoms, as in epilepsy, may be obtained by the determination of the suitable maintenance dose in individual cases.

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A full-time course. In Obstetrics: Lectures; prenatal clinics witnessing normal and operative deliveries; operative obstetrics (manikin). Gynecology: Lectures; touch clinics; witnessing operations; examination of patients, pre-operatively; follow-up in wards post-operatively. Obstetrical and Gynecological pathology. Regional anethesia (cadaver). Attendance at conferences in Obstetrics and Gynecology. Operative Gynecology on the cadaver.

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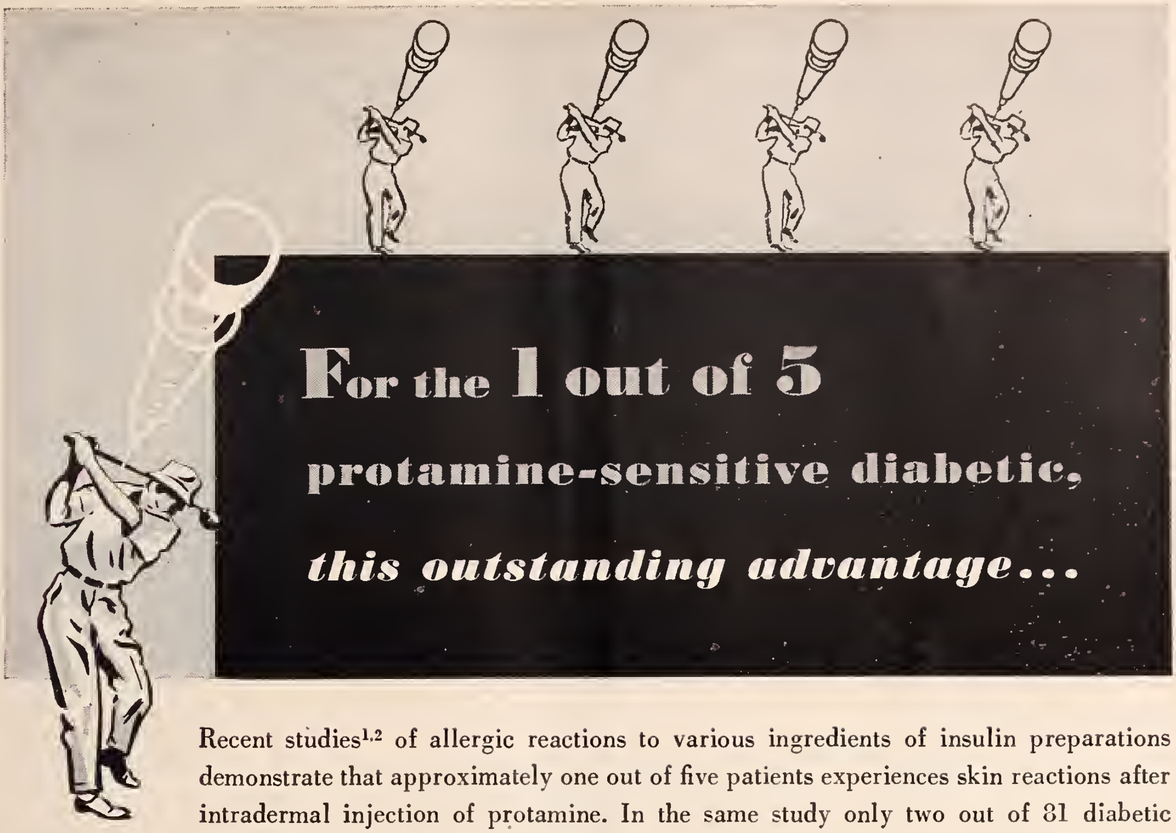

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Recent studies[1,2] of allergic reactions to various ingredients of insulin preparations demonstrate that approximately one out of five patients experiences skin reactions after intradermal injection of protamine. In the same study only two out of 81 diabetic patients exhibited sensitivity following the intradermal injection of globin.

Bauman,[1-3] and Duncan,[4] as well as others, have reported that patients who suffered from severe skin reactions following the use of protamine zinc insulin obtained immediate relief upon changing to globin insulin with zinc.

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(1) Page, R. C., and Bauman, L.: J.A.M.A. 124:704 (March 11) 1944. • (2) Bauman, L.: Bull. N. E. Med. Cen. V:17-21 (Feb.) 1943. • (3) Bauman, L.: Am. J. Med. Sc. 198:475 (Oct.) 1939, ibid. 200:299, 1940. • (4) Duncan, G. G., Diseases of Metabolism, Phila., Saunders Co., 1942, p. 782.

'WELLCOME' GLOBIN INSULIN WITH ZINC

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BURROUGHS WELLCOME & CO. (U.S.A.) INC. 9-11 E. 41st St., New York 17

Should the Navy serve Beer?

An interesting discussion of this question appears on the editorial page of Collier's for July 1, 1944

ACME, the beer with the high I. Q. (It Quenches!) has been an ever-increasing favorite in the West, every year since Repeal. A light beer, it is the popular refreshment with many who keep a constant weather eye on their waist lines . . . for ACME is far lower in caloric value than many so-called diet foods!

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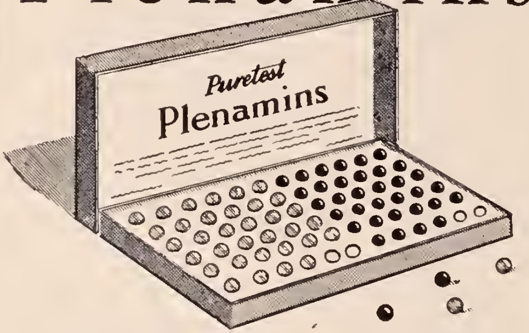

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They used to laugh at
"FLYING MACHINES"

Remember the days when people scoffed at the "dreams" of a few men . . . dreams of the average American "taking to the air"? Year by year, increasing numbers of travelers . . . no longer chained to earth by fear and ignorance . . . whisk through the air and accept it as a regular part of life.

There were days, too, when people avoided MARGARINE. But that was yesterday. Fortified MARGARINE'S present vitamin A content, its nutritious American fats which provide the important unsaturated fatty acids, plus its increased palatability, sweetness, freshness and . . . ease of digestibility . . . have made it an outstanding nutritious spread and cooking fat.

Prejudice against Fortified MARGARINE is as ridiculous as would be a prejudice against the modern airplane, for this energy-producing food is part of the seven basic food groups needed for good nutrition.

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The insult of anesthesia, tissue manipulation, unavoidable trauma, and enforced starvation sharply raise the nutritional requirements of the postoperative patient. Hence feeding must be started as early as possible to prevent too great a nutritional imbalance. Also, recovery is hastened and strength is gained more quickly when postoperative metabolic needs are supplied adequately.

Usually tolerated as early as liquids are retained, Ovaltine as a beverage provides a simple yet highly effective means of improving the nutritional state of the postsurgical patient. Its essential nutrients, well balanced and generously supplied, are in easily assimilated form. Thus the digestive burden is materially reduced. The delicious taste of this food drink proves appealing to all patients, young and old, making Ovaltine acceptable when many other foods are refused.

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Three daily servings (1½ oz.) of Ovaltine provide:

	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
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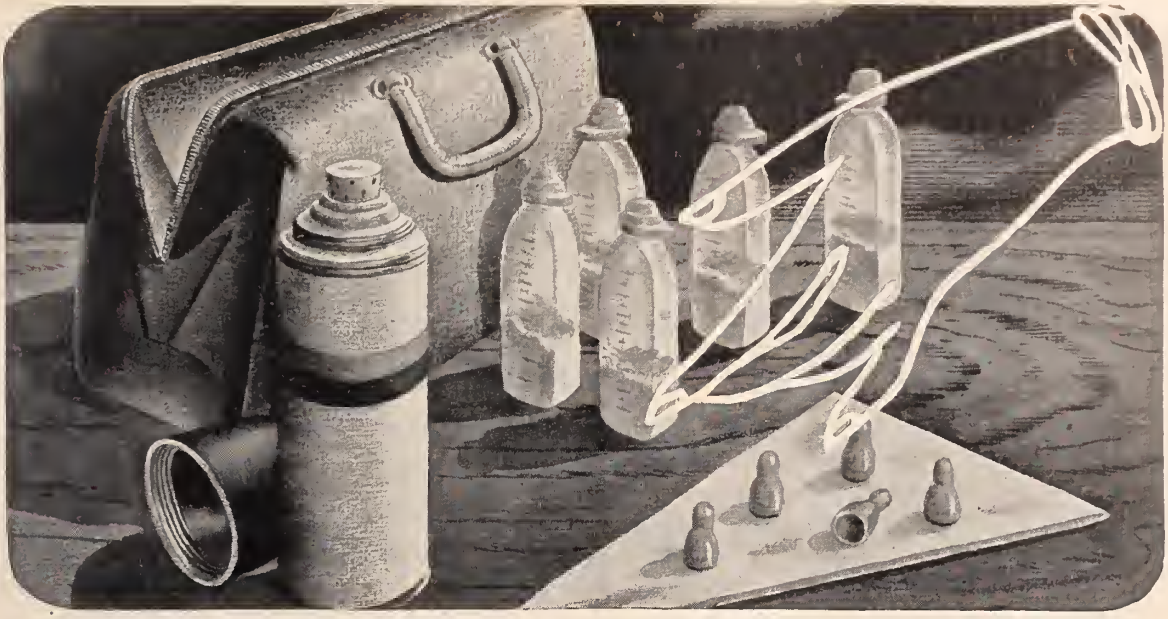
IRON	10.5 mg.	11.94 mg.	COPPER	.5 mg.	.5 mg.

*Each serving made with 8 oz. of milk; based on average reported values for milk.



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SIMILAC
A FOOD FOR INFANTS
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Net weight one pound

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Similar to breast milk

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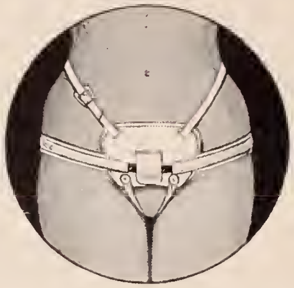
The Hittenberger Ptosis Spring and Pad



The lightweight unique appliance embodies all of the essential elements contained in the Hittenberger patented Ptosis Supporter and permits the patient to wear any corset or girdle over same. Our staff of expert fitters is highly trained to take care of every detail of ptosis supporter fitting and patients are thoroughly trained in proper methods of wearing and applying them.

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For the Education and Psychiatric Treatment of Children of Average and Superior Intelligence. Boarding Home Facilities.

TOPEKA, KANSAS

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

G. G. Moseley, M.D., San Francisco.—The doctor has become an important factor in modern industry, and the application of his knowledge to industrial conditions has developed a new specialty in medicine. Industry is responsible for its damage to human machinery, and the proper treatment of injuries arising out of industrial accidents is a question which should receive the serious attention of the medical profession. It should be demonstrated to both the employer and employe that the organized profession stands for the very highest class of service, and by men who are capable of doing good surgery. . . .

From an Article on "Prostitution in its Relation to Public Health in San Francisco," San Francisco Department of Health, per William C. Hassler, M.D., Health Officer.—During the month of August, 1917, the San Francisco Board of Health, at the request of the War Department of the United States Government, and in accordance with a plan outlined by the Army and Navy through the Commission on Training Camp Activities, established a clinic at the City Prison for the purpose of examining for venereal disease all persons arrested by the Morals Squad as vagrants or on the charge of prostitution. . . .

Conclusions

1. Suppression of prostitution in San Francisco has proven practical and successful, and justifies a continuation of the same law and enforcement measures during normal times that were started as a war measure.

2. That a venereal disease hospital should be maintained by the city as a public health measure, supplemented by clinics where proper treatment without cost

(Continued on Page 42)

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Velvet Smoothness

The process used in manufacturing the "RAMSES"* Flexible Cushioned Diaphragm produces a dome which is soft and pliable and can best be described as being as smooth as velvet.

This velvet-smoothness lessens the possibility of irritation during use.

The "RAMSES" Flexible Cushioned Diaphragm is manufactured in sizes of 50 to 95 millimeters in gradations of 5 millimeters. It is available on the order or prescription of the physician through any recognized pharmacy.

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Indications	Formula
For all genito-urinary infections, particularly the irritateed bladder of Prostatics	Calcium Carbonate Magnesium Carbonate Sodium Chloride Sodium Phosphate Sodium Bicarbonate
Pre- and Postoperative Treatment	
Fluid Depletion	
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Sparkling Palatable Not a Laxative

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THE CALSO COMPANY
524 Gough St., San Francisco, Calif.
CALSO WATER is not a laxative.

TWENTY-FIVE YEARS AGO

(Continued from Page 40)

can be administered.

3. That segregation should be made at the hospital which will tend to separate the beginner who is normal from the defective and hardened case.

4. That the State should provide a place where the subnormal and defective can be sent and cared for after curing of the acute condition for which they were quarantined.

5. An industrial farm should be maintained by the State where the normal and border-line case can be sent for rehabilitation physically, and where mental and vocational training may be had to fit them into the scheme of life which is possible only after a period of absence from the surroundings which enslaved them.

6. Without such coördinated and correlated connections, the present system offers us no hope for the greater percentage of the women, as it cures them for the time being of their acute troubles and throws them back into the mill to be ground over again.

San Francisco Board of Health,
Per Wm. C. Hassler, M. D.,
Health Officer.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 128)

"Dr. M. A. Thompson, 45, North Sacramento chiropractor, is held in the county jail on a charge of abortion on the complaint of a 17-year-old unmarried Sacramento girl, who said she received two abortion treatments from him. The girl gave birth to a premature baby in the Sacramento Hospital, Friday. The child

(Continued on Page 46)

when apathy prolongs convalescence

Many convalescent patients, faced with the "drab succession of dreary days", may develop a reactive depression which can markedly retard normal recovery.

This depression may manifest itself in symptoms of apathy, hopelessness or despondency, psychomotor retardation and subjective weakness.

Obviously, the physician should guard against undue stimulation. But when, in his judgment, a convalescent patient will benefit by a sense of increased energy, mental alertness and capacity for work, the administration of Benzedrine Sulfate Tablets will often accomplish the desired result.

BENZEDRINE
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(racemic amphetamine sulfate)

As with any potent therapeutic agent, Benzedrine Sulfate should be administered under the supervision of the physician. Indications and contraindications are set forth in N.N.R.

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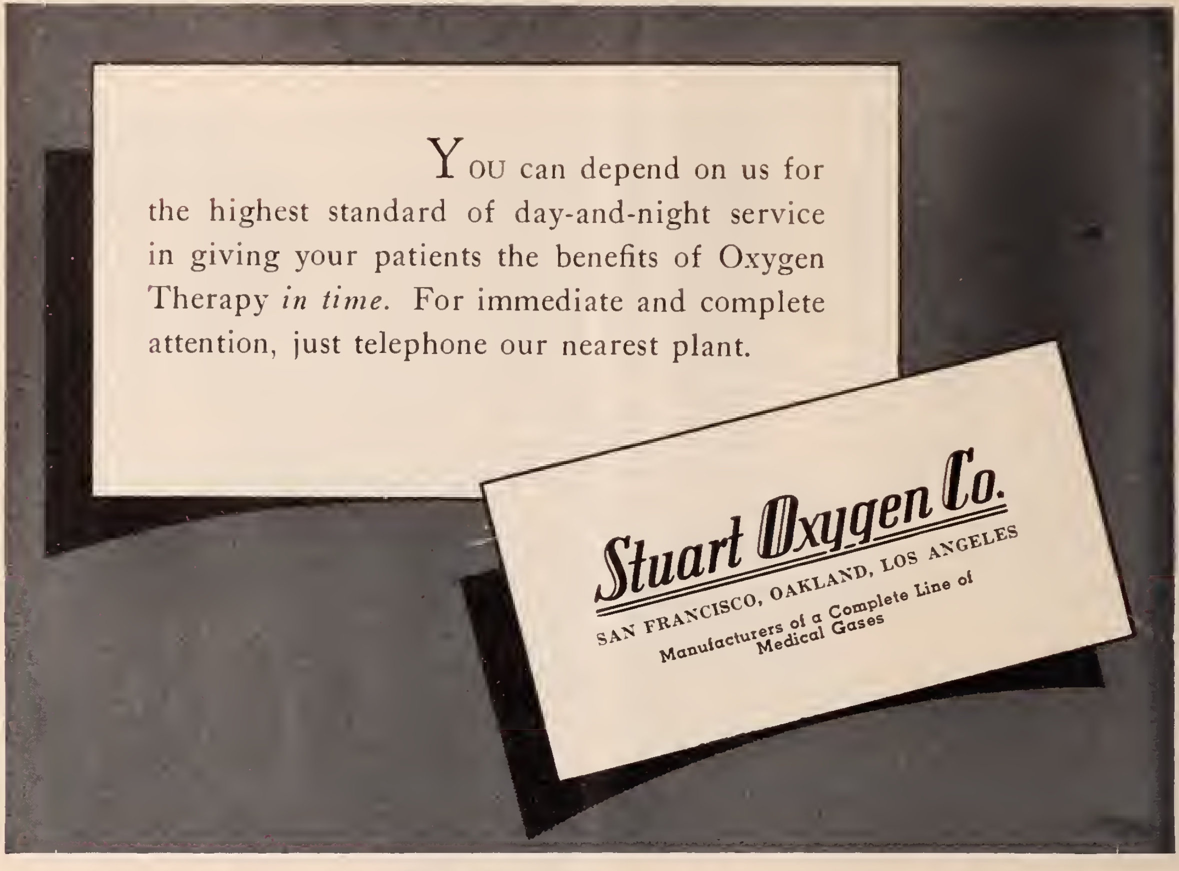

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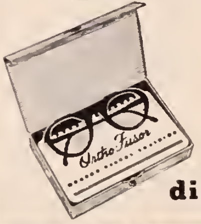
Manufacturers of a Complete Line of Medical Gases



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*With men in the Army, the Navy, the Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)

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CHOICE QUALITY
BUY WAR BONDS STAMPS

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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410.
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(Continued from Page 42)

weighed only 2½ pounds and died 12 hours later. . . . The authorities say Thompson claims the girl asked him to perform an abortion, but he refused. . . . The formal complaint was filed by the district attorney's office in Municipal Judge James M. McDonnell's court today. It was signed by the girl's father. Judge McDonnell set the bail at $2,000 bond or $1,000 cash. . . ." (Sacramento *Bee*, June 19, 1944.)

"Leslie Willey, former head of the Industrial Hospital at 2830 West Central, Newport Beach, withdrew his not guilty plea and plead guilty to one of the four counts against him, that of practicing as a doctor without a license, and paid a fine of $250 in City Judge O. A. Jones' court last Friday. The other counts set forth in the complaint sworn to by the State Board of Medical Examiners and signed by Maynard C. Young,—which included one for violating the health and safety code of the State, alleged illegal practice and another for practicing as a doctor without a State license,—were dropped. At the hearing on May 18, trial was set for June 6, but the case was settled four days prior. . . ." (Newport Beach *News-Times*, June 6, 1944.)

"A stay of execution from a sentence of life imprisonment today was granted by the District Court of Appeal to Mrs. Jean Simpson, 33, convicted of participating in the kidnaping and robbery of Dr. Robert Kotischek, Beverly Hills physician. She will remain in the County Jail pending a hearing on her appeal for a new trial." (Hollywood *Citizen-News*, June 22, 1944.)

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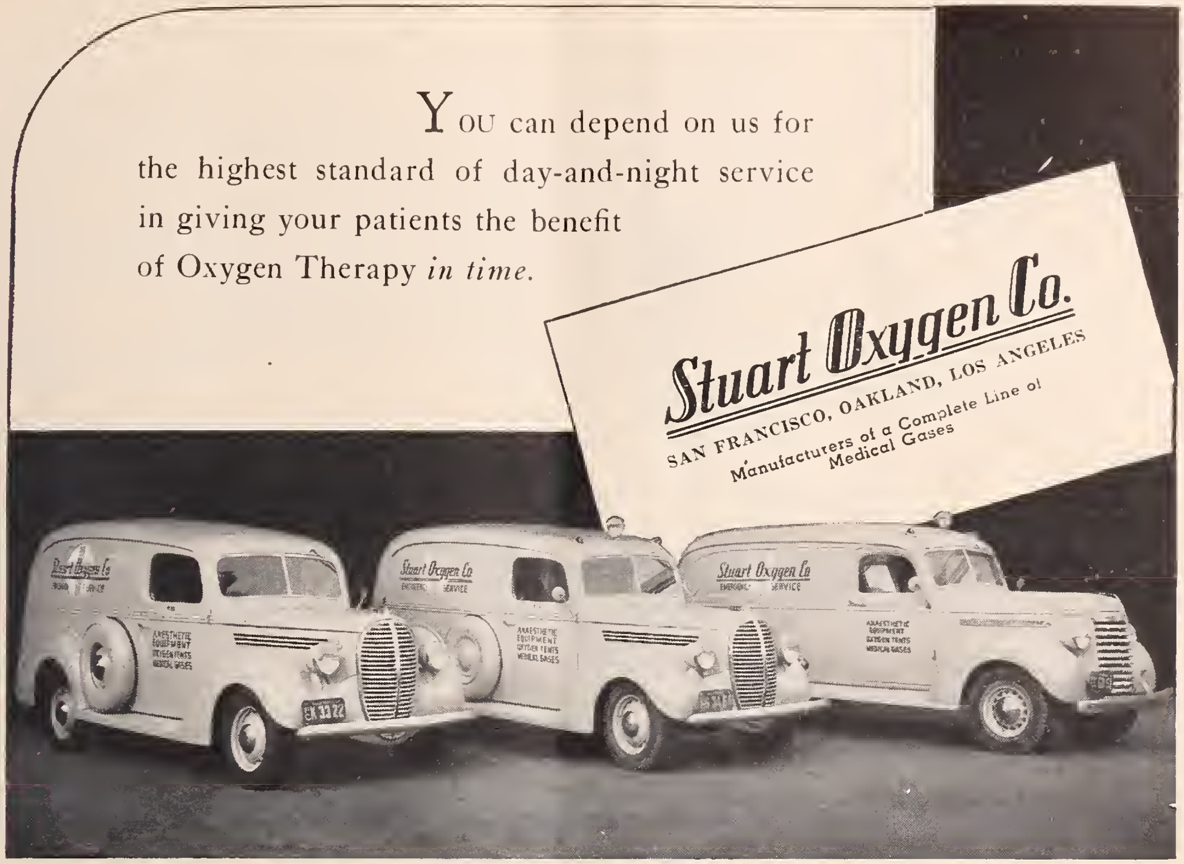
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Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Kenneth L. Dole, Medical Arts Building, Redlands.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
President, R. H. Sundberg, 2001 Fourth Avenue, San Diego, 1.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego, 1.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Stanley H. Mentzer, 450 Sutter Street, San Francisco, 8.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco, 2.
Meeting, *Second Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco, 9.*

San Joaquin County Medical Society
President, Warren T. McNeil, Medico-Dental Building, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton 3.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
George K. Dunklee, 1130 Garden Street, San Luis Obispo.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Fourth Wednesday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Erma B. Macomber, 1515 Broadway, Burlingame.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, H. L. Schurmeier, 6 E. Arrelloga Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, George A. Gray, Sainte Claire Building, San Jose, 23.
Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

Santa Cruz County Medical Society
President, Anton J. Sambuck, Union Street and Maple Avenue, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, Roy W. Thomas, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidrickseu, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, H. Randall Madeley, P. O. Box 539, Vallejo.
Secretary, Charles H. Widenmanu, 405 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, William N. Makaroff, Guerneville.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Ralph E. Maxwell, 911 Thirteenth Street, Modesto.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, James C. Malcolm, 1501 West Main, Visalia.

Ventura County Medical Society
President, A. H. Stoll, 329 North Fifth Street, Oxnard.
Secretary, Gerald K. Ridge, 704 East Santa Clara Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, J. Homer Woolsey, Woodland Clinic, Woodland.
Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Joseph J. Salopek, 423 Fourth Street, Marysville.
Secretary, Harry Clemens, 725 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(For roster of C. M. A. committees and other organizations, see last month's issue)

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(Continued from Page 3)

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 364 Fourteenth Street, Oakland, 12; 153 Kearny Street, San Francisco; 675 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles 5. Phone FItzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, also maintains a medical literature packet service.

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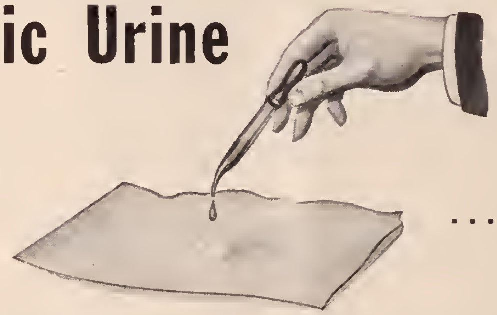

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BOOK REVIEWS

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1943. Cloth. Price, postpaid, $1.00. Pp. 150. Chicago: American Medical Association, 1944.

The present volume of reprints contains only eight reports on rejected articles; it is interesting to note that objections to these are on a much higher plane than those it was necessary to urge against the flagrantly quackish preparations of earlier days.

Perhaps the most noteworthy of the nineteen general and "status" reports in this volume is the one declaring the Council's intention of using henceforth only the metric or centimeter-gram-second system in its publications. The report itself gives some interesting and readable history on the subject of weights and measures. Of most timely interest to the general physician as well as the endocrine specialist is the report on nomenclature of endocrine preparations. The report gives a currently quite complete list of the available commercial preparations, including those not accepted by the Council as well as those which stand accepted. Another report in the field of endocrinology is that recognizing the use of estrogens in the treatment of prostatic carcinoma.

Standard Bodyparts Adjustment Guide. Traumatic Cases; Occupational Diseases; Disability Evaluations; Medical Fees, and Statutory Digests. Illustrated. Chicago: Insurance Statistical Service of North America, 1941.

This book is designed as an aid in correcting an

(Continued on Page 10)

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BOOK REVIEWS

(Continued from Page 7)

anomalous situation confronting Claim Adjusters, Lawyers, and Insurance Officials, when called upon to interpret the nature and background of an industrial injury or an occupational disease. The Adjuster, being a layman, needs to acquire a practical physiological knowledge of the human body, so that he may intelligently discuss the Claimant's case with Physician, Company Officials, Industrial Commission, Claimant, or his Representatives.

The anomaly consists in accentuating the legal aspects of a case, and in disregarding the compensable degree of a disability. This peculiarity is realistically reflected in the fact that such a large percentage of claims are settled without reaching the litigation stage.

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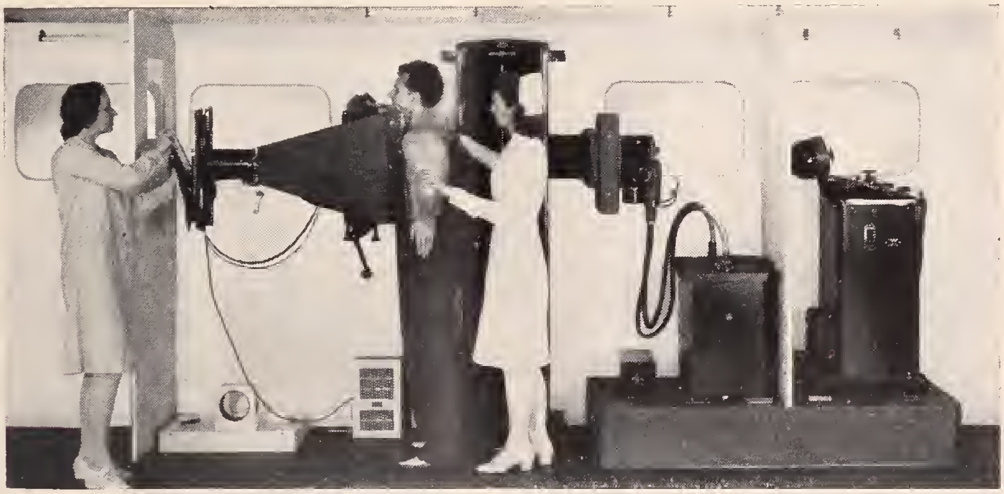

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Public Health

Selective Service's report on the physical condition of the Nation, as disclosed by its draft examinations, is a picture of mankind under civilization. However, lest we be tempted to go back to the primitive life, the medical men say a similar picture exists amongst uncivilized peoples. It is a picture to be found everywhere where the forces of nature no longer operate fully to weed out every individual touched by any weakness. The same thing is found amongst the protected deer in our public parks.

Yet this does not mean, either, that we should restore the law of fang and claw in order to bring the race of man back to par. If we have had intelligence enough to produce the protected conditions under which the race weakens physically we should have intelligence enough to use these conditions to keep the race at its best.

We have the intelligence and modern science has produced the knowledge. What we have lacked is enough spirit of go-at-it-and-do-it. We are heedless until we are appalled by such a revelation as this which a great emergency has brought us. We are still in danger from forgetting the revelation when the emergency is over.

We shall be stupid if we forget. Human health is one of the most vital of our cares. Collectively, through government, we should take this on as a chief problem. It is one that we can go for without divisions, for there is nothing political about it. If any try to make it so, they are obstructors of the cause and should be squelched as such.—Editorial in San Francisco *Chronicle,* July 12.

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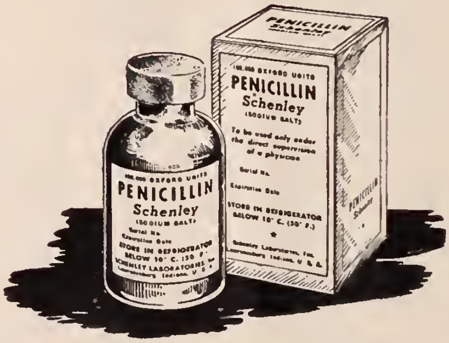
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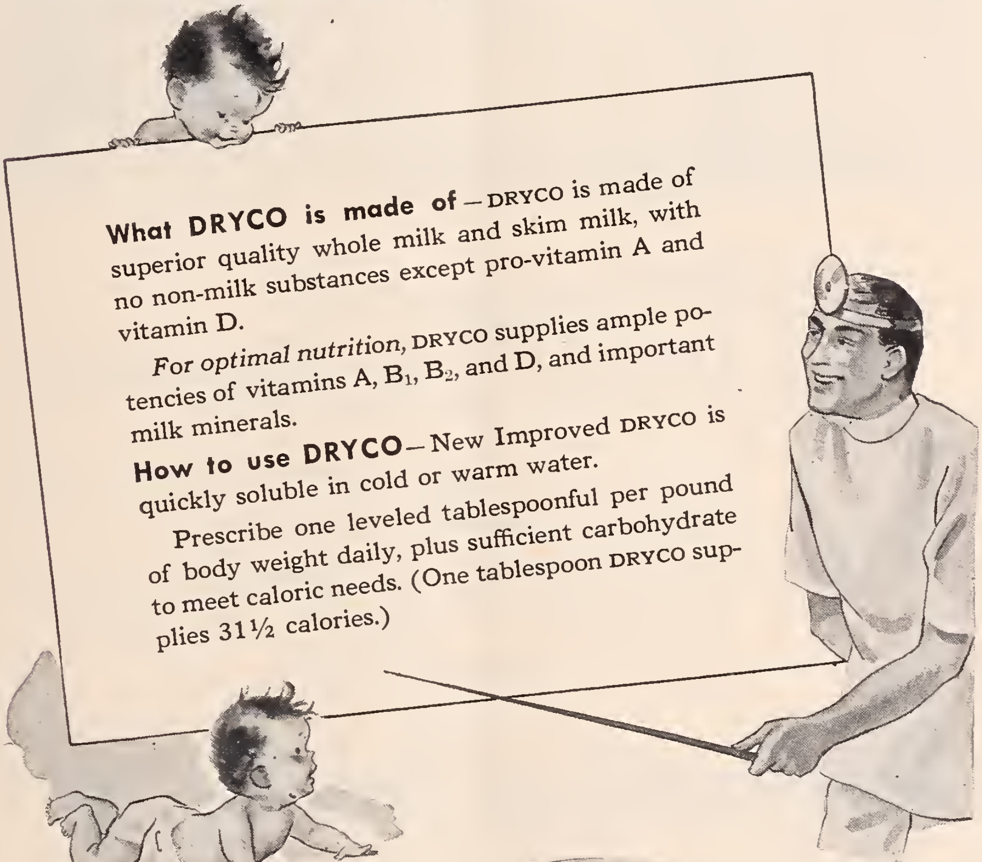

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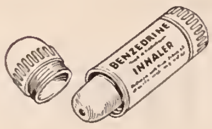

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 178)

We are limited to consideration of what constitutes a fair and adequate examination for a medical student or a doctor.

Dr. George Blumer, dean of the Yale Medical School, discusses this topic with eloquence and forethought. He summarizes the subject under six points which should be comprehended in each examination. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Pregnancy After Uterine Suspension," by Ludwig A. Emge, S.B., M.D., San Francisco.—Much has been written about the dangers to parturient women arising as the result of previous ventral suspensions, or suspensions where ventral fixation has occurred. In spite of this, the operation, which time after time has been warned against, still enjoys popularity among some surgeons. The explanation may be twofold. These surgeons either have no occasion to attend the same patient in their confinement, and consequently do not see the often unhappy outcome due to dystocia, or they prefer the operation on account of the absence of technical difficulties. . . .

From an Article on "Will the War Influence the Practice of Medicine, as a Business," by John C. King, M.D., Banning, Cal.—We hear much of reconstruction after the war. The meaning of the term, as applied to medicine, is quite as vague as when applied to business. No one knows its signficance. Business men either fear or hope for certain changes. The ones they fear they call

(Continued on Page 22)

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

destructive; those hoped for they term reconstructive Leaders of medical thought and writers of editorials in Medical Journals have expressed the conviction that the War has resulted, or will result, in certain profound, though as yet undefined, changes in the relations of physicians to each other, to the public or both. Among other points, stress has been laid upon the supposed facts that returning soldiers and their friends will demand a higher grade of professional ability than they had been accustomed to receive prior to the war; that more intense specialization will be required; that fewer fads and isms will be tolerated; that better hygienic conditions will be demanded; that owing to experience in camp and field physicians themselves have undergone inscruitable changes for the better; that, owing to these and other considerations, the practice of medicine, as a business, must adapt itself to new conditions. To most of these premises I respectfully dissent. . . .

From an Article on "Infections of the Oral Cavity and Their Relations to Systemic Diseases," by H. C. Bagby, M.D., Santa Barbara, Cal.—It affords me great pleasure to present for your consideration a paper bearing on one of the very important subjects in physical ailments, namely, the relation of infected foci of the mouth and systemic diseases.

I wish, however, to state that I realize that there are many other sources of infection other than the oral cavity and its appendages. Any organ may be the focus. . .

(Continued on Page 26)

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

From an Article on "The Epidemic of Filaria-Onchocerca," by William Thomas Fee, U. S. Consul at Guatemala City, Guatemala, September 29, 1917.—There has been discovered in the Republic of Guatemala, by Dr. Rodolfo Robles, a new disease of parasitic origin, hitherto unknown in the American continent, commonly called Erysipelas of the Coast; produced by infection of a parasite—Filaria Onchocerca.

The disease exists in a zone that ranges in an altitude between 2,000 and 4,000 feet above sea level, and it is supposed to be transmitted from person to person by the bite of a special genus of mosquito or fly, which is found only in the zone where the infection is existing. . . .

From an Article on "Increased Spinal Fluid Pressure as an Indicator of Meningeal Disease," by H. G. Mehrtens, M.D., San Francisco.—Increased spinal fluid pressure has long been recognized as a sign of meningeal inflammation. Its importance has been frequently emphasized, but its routine use has been delayed both by difficulties in securing an accurate reading and in interpreting these findings. . . .

From an Article on "The Rapid Administration of Digitalis in Cardiac Decompensation," by W. E. Kay, M.D., and J. M. Tufts, M.D., San Francisco.—Digitalis medication has suffered in the past from this drawback: that the usual doses given by mouth do not produce a physiological effect until several days have elapsed. During this lapse of time the drug is accumulating in the

(Continued on Page 34)

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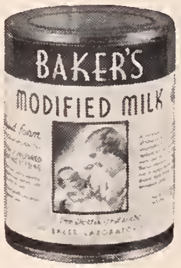

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 61 SEPTEMBER, 1944 NO. 3

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

Committee on Publications

Francis E. Toomey.........................San Diego 1945
George W. Walker (Chairman)..............Fresno 1946
F. Burton Jones............................Vallejo 1947
Secretary-Editor ....ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

ON DEVELOPMENTS IN MATERNITY-PEDIATRIC (E.M.I.C.) PROGRAM OF FEDERAL CHILDREN'S BUREAU

County Medical Societies to Appoint Local Committees.—The central C.M.A. Committee on Maternity-Pediatric Work (Karl L. Schaupp, Chairman) under date of August 31st, sent a letter to the county medical societies in California, suggesting the appointment of local committees on E.M.I.C. activities. A copy of the letter and its addendum, "Recent Rulings of E.M.I.C. on C.M.A. Suggestions," appears in this issue on page 160.

* * *

Explanatory Comments on the Addendum.—It may be in order to add further comment concerning the addendum, where numerical references correspond to those below.

1. Because some patients coming under the E.M.I.C. program are able and willing to pay a physician whom they select, a supplementary fee, that is, a fee in addition to the $50.00 E.M.I.C. allocation (it to be stated in the contract signed by the physician that the patient is able and willing to pay a supplemental fee, the exact amount also being stated), the California Committee deemed it in order to suggest that a supplemental fee, under such stipulation, be permitted.

The officials of the Federal Children's Bureau disapproved the above request.

In passing, it may be stated that the $50.00 fee insisted upon by the California Committee (instead of the $35.00 and lower fees originally suggested by the Federal Children's Bureau representatives) has now become operative, practically in all States of the Union. The profession throughout the country can thank California for that service.

Because the $50.00 fee does not, in places, cover California costs, it seemed fair to suggest that supplemental fees, as above safeguarded, be sanctioned. However, the Federal Children's Bureau disapproves and there the matter rests; presumably, perhaps, because in some sections of the United States, a $50.00 fee is deemed sufficient. Many California physicians are required, therefore, to make donation in part, of their professional services.

2. Nor would the Federal Children's Bureau consent to an arrangement whereby a physician,

if he did not make five prenatal examinations (when patients did not come to him in ample time) suffer no financial deduction from the $50.00 allocation.

Here again the Federal Children's Bureau said, "No."

Note.—Negotiations concerning this request are still being carried on.

3. In the original E.M.I.C. plan, in those cases where, in smaller communities, the attending physician must rely on his own laboratory equipment, such as x-ray, or on his own surgical skill to do, say, a Caesarean section, there would have been no extra compensation over the standard $50.00 fee, for services so rendered by him.

However, if such attending physician had called in some other physician or specialist for such service, the extra fee would have been allowed. This did not seem fair.

The California Committee suggested, under such conditions, that an attending physician to the pregnant woman, who gave such extra service, be allowed the additional fee that would be granted to a consultant.

Here also, the Federal Children's Bureau could not see eye to eye with the California Committee, and the suggestion was disapproved.

4. The E.M.I.C. plan stipulated qualifications of specialists, emphasizing certification from a national specialty board, or eligibility to take the examinations of such a board.

The California Committee called attention to the fact that, in many rural and smaller communities, such certificated specialists are not available and made the suggestion, when such certificated consultants were not to be had, then the attending physician should be permitted to call in a local colleague, who, in private practice would have been asked in consultation, in a similar, complicated case.

To this suggestion, the Federal Children's Bureau gave approval.

5. The earlier E.M.I.C. contracts provided that when a specialist obstetrician did no pediatric work, he might call in a pediatrician to look after the infant, the pediatrician receiving pay for such service.

However, an attending physician who was giving care to the mother, and who did not desire to be responsible for the care of the infant, was not given the same privilege of calling in a pediatrician.

The California Committee recommended that the rule should be modified to permit the attending physician to have the privileges under such circumstances, similar to those given to a specialist obstetrician.

This recommendation was approved by the Children's Bureau.

6. In conjunction with the Bureau of Maternal and Child Health of the California State Board of Public Health, the California Committee submitted a simpler form of contract, in which the dangerous legal elements concerning "complete" and "required" care were eliminated. (For discussion of this phase, brought out by Dr. William Benbow Thompson of Los Angeles, see the legal opinions printed in CALIFORNIA AND WESTERN MEDICINE, for August, on pages 114-116).

The Federal Children's Bureau agreed to delete the dangerous terms; and accepted, in part, a simpler form of contract submitted by the C.M.A. Committee.

* * *

State Board of Public Health and California Committee on Maternity-Pediatric Care Have Been Working in Coöperation.—These explanatory comments are here given, to supplement the information which appears in this issue, on pages 160-161. Also, so that members of the C.M.A. may know that the C.M.A. Committee on Maternity-Pediatric Care has been making consistent efforts to bring about an improvement in the E.M.I.C. program of the Federal Children's Bureau.

The C.M.A. Committee will welcome further suggestions from the County Society Committees now being appointed.

Physicians should keep in mind that the Federal Children's Bureau must work through a constituted State agency, as regards disbursements of Federal monies; and that the California State Board of Public Health, in turn, must pass on the Federal set-up, as submitted, to the local health officials for further coöperation.

Also, that from the beginning, the California Bureau of Maternal and Child Health has given full coöperation to the C.M.A. Committee on Maternity-Pediatric Care, in efforts to bring about improvements in the E.M.I.C. plan drafted and promulgated by the Federal Children's Bureau of the United States Department of Labor.

CALIFORNIA PHYSICIANS' SERVICE REPAYS THE LOAN OF $35,000 FROM C.M.A.

Continued Progress of C.P.S.—Recent issues of the OFFICIAL JOURNAL have carried articles on the work of California Physicians' Service, the statewide medical service organization brought into being by the California Medical Association. A report on the "First Five Years of C.P.S." appeared in the April number, on page 191; and in the June issue, on pages 329-333, were given the minutes of the Los Angeles meeting, whereby, under the new arrangement, the members of the C.M.A. House of Delegates become a majority group of the Administrative Members of California Physicians' Service.

In the August issue, on page 51, attention was called to the present unit value of $2.25, and the installation of a system that will make for prompt payment of statements rendered by physicians, for their professional services. Also, to the important fact that C.P.S., which did a gross business of $1,340,315.00 last year, is now a business organization possessing assets sufficient to cover all liabilities.

Members of the California Medical Association may take pride in the knowledge that their statewide plan for medical service, as exemplified in California Physicians' Service, has successfully passed through its infancy days; and though still in what may be called a childhood period, is now an institution that gives every promise of continued growth and successful development.

It is likewise gratifying to record, at this time, that a loan originally advanced to C.P.S. by the California Medical Association, has been fully repaid through a check for $35,000.00, received on August 23, 1944. A photograph has been made of the check, and a reproduction appears in this issue on page 169.

With generous coöperation by all members of the California Medical Association and associated groups, it should be possible to solve most of the medical service and hospitalization problems still existing. Once that is done, California Physicians' Service will be in position to move forward at an increased pace. That day, for the future good of the medical profession and the health of the people, cannot come too soon. As stated, it will come to pass, if every C.M.A. member will give wholehearted support.

TUBERCULOSIS SUPPLEMENT IN AUGUST C. AND W. M.

Many Articles of Interest and Value.—In California and Western Medicine's issue of July, 1943, on pages 25-70, and this year in the August number, on pages 75-109, appeared some 50 articles or digests on pertinent problems and recent studies in tuberculosis. The two tuberculosis supplements presented information worthy of, at least, a casual inspection. While it is true that the "Battle Against the Great White Plague" reveals much progress, the fight has not been won, by any means; for, as Osler stated years ago, "Tuberculosis is a social problem with a medical aspect." In other words, since tuberculosis is a disease having causative elements closely associated with poverty, malnutrition, over-work, improper housing, as well as factors such as faulty habits, poor heredity and previous diseases, the struggle to eliminate the disease must go on until the accessory social welfare elements are gotten under control. Nevertheless, since it is an infectious disease, and of such, one of the most widespread in relation both to morbidity and mortality, it will continue to receive the earnest study not only from physicians but also from social welfare students and workers. Witness, for example, the statistics in the "Weekly Report of the Department of Health of the City of Los Angeles," of date of September 2, 1944, as given in a summary of communicable diseases in Los Angeles for the fiscal years 1942-1943 and 1943-1944. For the ten leading communicable disease causes of death in that city, tuberculosis was at the top of the list for both years; with 822 deaths in 1942-1943, and 795 deaths in 1943-1944.

Readers who have not looked over the articles presented at this year's annual meeting of the California Tuberculosis and Health Association, may wish to take the time to scan them.

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California Physicians Have Been Leaders in the Work.—As regards the incidence of tuberculosis, members of the medical profession may take pride in the educational work that has been carried on in California. The more so, since both the tuberculosis associations in the State (the seventh anti-tuberculosis organization to be organized in the United States was the Southern California Society for the Study and Prevention of Tuberculosis) and the California Tuberculosis Commission which brought in its report to the Legislature in 1914, were in good part the brain children of physicians; going through their developmental days, largely under the administrative supervision of physicians.

* * *

Annual Christmas Seal Sale Exceeds One Million Dollars in California.—Doctors of Medicine who wish to note what their respective local groups have done in providing work funds through the Christmas Seal sales, will find such a summary on page 109 of the August issue of California and Western Medicine. It is heartening to know that, with the passing years, an increasing number of citizens take real interest in the continued efforts to eradicate tuberculosis; as witness the fact that more than one million dollars, through purchase of the Christmas Seals is now being annually collected in California. This is a good sign, since the monies, so raised, lay the foundation for even better results in the days ahead.

A LAPSE OF MEMORY, OR WHAT?

Valuable Articles on "Public Relations."—In California and Western Medicine for July, the opening article on page 10 was entitled, "Public Relations Survey of California." The article was the report presented at this year's annual session of the California Medical Association by Mr. John R. Little, who represented the firm of Foote, Cone and Belding, and dealt with the results of an investigation and study made for the C.M.A. in November, 1943. In California and Western Medicine, for May, on page 241, appeared an "Interpretative Report" of this recent survey of California public opinion.

For this investigation and report, the California Medical Association paid some eight thousand dollars. The detailed and factual data were submitted to the C.M.A. in a 232 page report, copies of which were sent to several officers of the American Medical Association in Chicago.

Concerning this recent survey of California public opinion, it may be said that the facts and conclusions drawn therefrom have had a powerful influence in creating among physicians of the State a better understanding of new problems in medical trends; which must be satisfactorily solved, if medical practice as it is carried on at the present time, is not to be radically changed through revolutionary procedures.

* * *

The Factual Information is of Value for Physicians in All States of the Union.—California is one of the largest States in the Union, with eight million population, possessing economic, social and other environmental factors, quite similar to those found in other commonwealths. Therefore, it is fair to assume that the valuable information obtained at considerable expense, and then brought to the attention of the medical profession of California, should also be of interest to physicians in other sections of the United States. That such is the case is shown by a reference to Mr. Little's report, in the *New York State Journal of Medicine* for September 1, in which the leading editorial on "Plain Talk, I," concludes with an excerpt from Mr. Little's report.

* * *

Seemingly Overlooked by J.A.M.A.—It might also be fair to assume that some publicity would have been given to Mr. Little's "Interpretative Report," when the same went over the desk of the Current Literature Department of the *Journal of the American Medical Association.* Not so, however, since the *J.A.M.A.* in its issue of August 12, on page 1064, does nothing more than to list the title.

However, in *Medical Economics,* which states it is a business publication with a circulation of 110,000 copies, extensive excerpts appeared in the July and August issues. Some publicity, therefore, has been secured.

It will be interesting to note whether Mr. Little's illuminating and very valuable article in the July issue of CALIFORNIA AND WESTERN MEDICINE will receive major, minor, or no comment in a future number of the official journal of our national organization,—the American Medical Association.

If no comment, why not?

EDITORIAL COMMENT†

COMBINED QUININE-SULFATHIAZOLE THERAPY

Four years ago a number of Japanese[1] and German[2] investigators reported experimental and clinical evidence that concomitant administration of quinine and sulfonamide is more effective against streptococcal infections than administration of sulfonamide alone. Harned[3] and associates of the Woman's Medical College, Philadelphia, have attempted to confirm their experimental evidence. Therapeutic tests were made on 289 mice, infected intraperitoneally with 0.5 c.c. of a 1:500,000 dilution of an 18-hour broth culture of hemolytic streptococci. Two days before this inoculation the mice were divided into 4 matched groups. One group of 73 mice was fed ground Purina dog chow. A second group was fed the same diet plus 0.3 per cent quinine ethylcarbonate. This form of quinine is almost tasteless to man, and is readily eaten by mice. A third group was divided into sub-groups which were given the same basic diet plus 0.025 to 0.3 per cent sulfathiazole. The fourth group was similarly subdivided and was given the same doses of sulfathiazole plus 0.3 per cent quinine ethylcarbonate.

The mice were kept on the therapeutic diets for 9 days (7 days subsequent to the infection) and then placed on drug-free dog chow for an additional 7 days. By the end of this period there were but 9 survivors among the 146 mice of the two control groups, i.e., the drug-free group and the group given quinine. This gives an average control mortality rate of 94 per cent. There was no suggested therapeutic action by the quinine alone, the mortality in the quinine group being 97 per cent.

In contrast with these control percentages, the sub-groups given sulfathiazole alone had an average mortality rate of but 43 per cent. This was reduced to 24 per cent in the sub-groups given sulfathiazole plus quinine.

From this it is evident that under the experimental conditions adopted by the Philadelphia investigators the concomitant administration of quinine about doubles the therapeutic efficiency of sulfathiazole. Whether or not this is also true for microörganisms other than Streptococcus hemolyticus has not yet been reported. While the present restrictions on quinine would make clinical applications difficult, the work may well warrant post-war clinical trial.

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Hegar's Sign.—Hegar's sign at once calls to mind the name of the gynecologist, Alfred Hegar, and of his original work in establishing an early diagnosis of pregnancy. One of the "old masters," as he might be termed, Hegar made many other noteworthy contributions that helped to advance the science of modern gynecology. For these works he will long be remembered.—Warner's *Calendar of Medical History.*

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

COCCIDIOIDOMYCOSIS: IN THE WESTERN FLYING TRAINING COMMAND*

Lt. Col. Russel V. Lee
MEDICAL CORPS, ARMY OF THE UNITED STATES
Santa Ana

THAT the unprecendented opportunity for study of coccidioidal infection which the mobilization and training of troops in the southwestern United States provided was not neglected, was due to the foresight of Colonel (now Brigadier General) Charles R. Glenn and his successors, Colonel Healy and Colonel Britton. Anticipating the situation which actually arose, they enlisted the coöperation of Dr. Charles E. Smith, as a Surgeon General's consultant representing the Army Epidemiological Board and, even before mobilization began, set in action a program of study and control which still functions, and which has already yielded information of inestimable value about this rather little known disease. That there was a hazard in putting troops into this area was recognized in the beginning. The decision that the climatic advantages for flying outweighed the hazard of coccidioidomycosis has been amply justified. The accident rate in flying training in this command has been the lowest in the country, and favorable flying weather has been the most important factor in achieving this record. Lives saved in this way far outnumber lives lost from coccidioidomycosis. And the incidental benefit with which we are concerned today is the unique clinical and laboratory experience furnished for observations on coccidioidomycosis. Unfortunately it is not yet possible to release exact figures of the numbers of men involved, and the final statistical analysis of our observations must rest until the war is over. But it is possible to give you an idea of what was involved in the program of the Western Flying Training Command. All new personnel coming on air fields are skin-tested when they arrive, and the negative reactions are retested six months later or when they leave the field if before this time has elapsed. All suspicious clinical cases in the dispensaries and hospitals are skin-tested during the course of the disease, and in addition specimens of blood are sent to Dr. Smith for confirmatory evidence when indicated. A campaign of medical education has been instituted. due to the fact that coccidioidomycosis was just news to most of the medical officers. A manual was prepared with x-ray reproductions, and this was distributed to all the stations and to many of the individual officers. A coccidioidomycosis control officer was appointed to supervise the data collected and to assist in the education of personnel. Dr. Charles E. Smith has visited the valley stations regularly once a month, and has been in constant consultation with Colonel Healy, Surgeon, Western Flying Training Command. As a result of this program, over a quarter of a million skin tests have been given, a thousand or more clinical cases recognized, nine complete autopsies done, and an enormous mass of statistical material has been collected.

GEOGRAPHICAL LIMITS OF THE ENDEMIC AREA

When these results are available it will be possible for the first time to define precisely the geographical limits of the endemic area—we are already prepared to state that the San Joaquin Valley is not the worst area by any means. We will have a pretty accurate measure of probable morbidity and mortality in any given area, of the percentage of subclinical to clinical cases, and the percentage of erythema nodosum, cavitation, and dissemination to be expected. We will be able to give an estimate of the economic cost and probably an improved picture of the clinical course and clinical types. This is the particular theme of my remarks today. The other data must wait until all the returns are in; but when it does come it will furnish, I believe, definitive answers to many questions.

CLINICAL CLASSIFICATIONS

From the clinical point of view various classifications are made. Dr. C. E. Smith has recently proposed one in the *Medical Clinics of North America*. The question is still open, so I propose yet another of my own. It seems to me that some clinical value may be had from grouping the cases as follows:

1. Primary.
2. Intermediate (or Pulmonary).
3. Advanced (or Disseminated).

The *Primary* form in the great majority of cases is subclinical. The only evidence of its having occurred is the finding of a positive skin test in an individual who was previously negative. This change of positive from negative will occur in about 10 per cent of personnel in the all over portion of this command, which includes both endemic and nonendemic areas, within six months. But some stations have reported as high as 80 per cent of the post population who stay six months turning positive. As the medical personnel and the men themselves become more aware of this disease, more and more of these subclinical cases will be recognized and properly diagnosed. Frequently, what would ordinarily pass as a cold or a mild influenza, "desert rheumatism," etc., is properly diagnosed as coccidioidal infection, when it is suspected. When erythema nodosum occurs, as it often does in this primary stage, the diagnosis, of course, is suspected much more frequently. There is no sharp borderline between this stage and the pulmonary phase, because many of the more severe cases show varying degrees of respiratory involvement.

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* Read before the Section on General Medicine, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

This article has been released for publication by the Review Branch, War Department Bureau of Public Relations. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the War Department, or the military service at large.

The *Intermediate (or Pulmonic)* stage is the one which is most frequently recognized clinically. This is an acute, subacute, or chronic pulmonary inflammation. Almost all degrees of pulmonary involvement are seen, from a mild bronchitis, with or without hilar gland enlargement, to a massive or disseminated pulmonary consolidation. The resemblance to tuberculosis has often been stressed, but there are certain differences which are recognizable with experience. Our roentgenologists seldom mistake it now. The clinical symptoms in relation to the x-ray findings show also certain definite differences from tuberculosis. Perhaps the most marked is the relatively better prognosis. In relation to the amount of pulmonary involvement a patient with coccidioidal infection will recover, where the outlook would be exceedingly grave were the diagnosis tuberculosis. But when the lesion is primarily apical, the confusion may be truly difficult. And with certain lower lobe lesions the resemblances to virus pneumonia are often striking. Cavities occur rather frequently, but have a much better outlook than do tuberculous cavities. They have thinner walls as a rule, and often occur spontaneously, so to speak, i.e., without a preceding area of consolidation. They show a very marked tendency toward spontaneous closure, although some have been observed to be open for seven months. There is another curious lesion almost pathonomic of this disease. This consists of a well-circumscribed nodule which looks very much like a metastatic carcinoma. These nodules are usually unaccompanied by symptoms, but are very slow in resolving. We have seen multiple patches of rather dense consolidation scattered all through both lung fields. In one such, about twenty small cavities developed, which closed, however, rather promptly, and the patient made a complete recovery. There are a few who develop massive consolidations and then recover, but this is usually seen in the fatal disseminated cases. We have found that about one-sixth of all cases which occur on every field are diagnosed as clinical coccidioidomycosis, and of these so diagnosed about 20 per cent will show skin lesions, usually erythema nodosum.

In the *Advanced (or Disseminated)* form, literally anything can happen. This outcome would seem to be about 100 times as likely to occur in the colored as in the white soldier. The mechanism of the occurrence of dissemination is not known, nor is the time in relation to the onset of the disease. The shortest time from onset to death was 63 days, the longest time was 200 days—the average elapsed time in the fatal cases was 3-4 months from onset to death. Thus it would appear, and a study of the records confirms, that dissemination, if it occurs, is likely to occur early. There has been one doubtful case of late dissemination almost five years after residence in an endemic area, but we have not observed any such. This is naturally a question of prime importance, for if we are going to see a large number of late disseminations from the men who have been infected in the desert area, the problem will be very difficult. In the disseminated cases almost every organ of the body has been involved. All the fatal cases showed pulmonary involvement, all showed lymph gland involvement, all but one showed some involvement of bones, the calvarium or meninges was involved in five cases, two out of the nine showed involvement of the spleen. In some cases the whole body was literally riddled with cold abscesses. A curious, and I believe previously unobserved finding, was involvement of the heart muscle in three cases. These showed infiltrations between the muscle fibres in which spherules were found, and in one case a small cold abscess in the wall of the ventricle. Unfortunately, EKG's were not made on these cases, but EKG studies are now being made on all, and one case is under observation now which shows abnormalities in the T-waves which may be significant. We have seen, incidentally, no less than four instances of pericardial effusion in patients who are apparently recovering. There have been a few cases of dissemination where apparent recovery occurred. The complete figures on these are not yet available, but seem to be about 20 per cent of the whole number of disseminations. That dissemination may be impending can often be anticipated from a rising titre in the complement fixation test. We have discovered no treatment that affects the course in any way. The sulfones are futile; our one case treated with penicillin received no benefit, and in vitro tests indicate that the fungus is not susceptible to penicillin. This has been confirmed elsewhere. Disseminated coccidioidomycosis was, as you all know, the first recognized manifestation and it is a truly terrible disease, especially for the darker skinned races.

SUMMARY

This now is a summary of our present ideas on coccidioidomycosis. It is an endemic disease in the San Joaquin Valley of California, the whole of Arizona and New Mexico, western Texas, northern Mexico, southern Nevada, and probably Idaho. A very large percentage of those who spend time in this region will be infected, generally with the inapparent subclinical form of the disease. Under the closest scrutiny one-sixth of the infections will be diagnosed and in practically all of the diagnosed cases some pulmonary involvement will be found. About 20 per cent of diagnosed cases will show skin lesions, and about 1 per cent of the diagnosed cases will develop dissemination, and four-fifths of these will die. The pulmonary involvement will always be found in the fatal cases, but in itself is rarely, if ever, the cause of death. We believe dissemination is less likely if the intermediate cases are kept at rest until the process subsides, but must confess ignorance at present as to the time or the route of dissemination. There is no specific treatment. (Slides.)

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Rh FACTOR IN INTRA-GROUP HEMOLYTIC TRANSFUSION REACTIONS*

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We have been inclined to think of blood transfusion as a safe procedure, if proper grouping and crossmatching of the patient and the donor are done. Nevertheless, in the past decade there have been increasingly numerous reports of hemolytic reactions following transfusions where apparently all precautions were taken to prevent reaction. The increase in such cases seen and reported is due, no doubt, to the great increase in the number of transfusions given. Various hypotheses have been advanced to explain these reactions, none entirely satisfactory until the discovery of the antigenic Rh factor in human blood by Landsteiner and Wiener[1] paved the way to an understanding of the mechanism of the majority of them. Briefly, the fundamental facts are as follows: We know that about 85 per cent of the population, at least of the white population, have the Rh factor in their red cells. We call them "Rh positive." In about 15 per cent this factor is absent. That is, these people are "Rh negative." This factor is an agglutinogen, but is independent of the group factors A and B, and of the factors M, N and P. Anti-Rh agglutinins develop under certain circumstances in Rh-negative individuals. The intragroup hemolytic reactions occur, for the most part, in two types of patients: (1) in women during pregnancy and the postpartum period, and, (2) in others, men or women, who have received one or more transfusions. In the first group the sensitization to the Rh factor comes about through the influence of an Rh-positive fetus in an Rh-negative mother. In the second, the repeated transfusions of Rh-positive blood into an Rh-negative patient stimulates the formation of anti-Rh agglutinin and presumably hemolysim, so that eventually the patient develops antibodies in such quantities that, when Rh positive blood is transfused into such an individual, it is destroyed. The Rh-negative individual, whose defense mechanism has not been stimulated by pregnancy or by the introduction of Rh-positive blood, does not have demonstrable anti-Rh agglutinins in her or his blood. Below are cited three cases illustrating the development of antibodies against the Rh factor and hemolytic transfusion reactions resulting from them.

REPORT OF CASES

Case 1.—A. H., male, age 46, admitted to the Hospital of the Good Samaritan, April 1, 1941, complaining of fever and loss of strength. A clinical diagnosis of subacute bacterial endocarditis was made, and the blood culture showed streptococcus viridans. The patient's blood was group B. His temperature rose to 101° daily. A transfusion of 500 c.c. of citrated blood group B was given on April 4th because of a mild secondary anemia. There was no reaction. The temperature was lower following this, and not until April 12th did it exceed 99°. On May 9th another transfusion of 500 c.c. of citrated blood was given, with no reaction. On May 23rd a transfusion of 500 c.c. of citrated blood was given, followed by a chill and rise in temperature to 104°. No hemoglobinuria was noticed, but next day there was an icteric tint to the sclerae and the icterus index was 20. On May 27th the icterus index was 17. This patient, however, had been receiving neoarsphenamine for treatment of his infection according to the method of Osgood, and it was thought the icterus might have been due to that On June 7th another transfusion of 500 c.c. of blood was given, followed by a severe chill and hemoglobinuria. No oliguria developed, but there was a definite icteric tint to the skin. Investigation of his blood following this transfusion revealed that he was Rh negative, and that his serum contained a fairly high content of anti-Rh agglutinins. On July 4th, 500 c.c. of citrated blood from a group O, Rh negative donor was given without reaction. On July 14th a group B donor, who appeared to be Rh negative when his blood was tested against the serum of the patient, was used. This agglutination was done as Wiener[2] then advised, that is, at refrigerator temperature; but apparently the method failed to demonstrate the Rh factor, since the transfusion was followed by a severe chill and evidence of hemolysis. Again no oliguria or evidence of permanent kidney damage developed. This donor was lost sight of, and his blood was not tested further, but it seems probable that he was Rh positive.

The patient had no further transfusions. He left the hospital and died from his endocarditis several months later. During the period of hospitalization he had several blood counts, all of which showed a lower red cell and hemoglobin content than the first count. However, he had a progressive disease, and he had intensive sulfonamide and arsenical therapy, so it was not possible to determine how much of the transfused blood was destroyed by the hemolytic reactions. Wiener[3] has expressed the opinion that, with the destruction of the transfused red cells, there may be destruction of some of the preëxisting cells, with the result that there is a lower red cell count after the transfusion than before.

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Case 2.—Mrs. H. I., female, age 43, married. She has nine children, the oldest 18 years, the youngest 13 months. All deliveries were normal and she had had no jaundiced babies and no miscarriages. She was admitted to the Good Samaritan Hospital with a diagnosis of tubo-ovarian abscess. She was operated upon March 10, 1942, and received a transfusion of 500 c.c. of citrated blood from her husband a short time after returning to her room. While her temperature rose to 101° by 4:00 P.M., this was thought to be a postoperative reaction rather than a transfusion reaction. There was no chill, no hemoglobinuria. However, she is said to have had a chill following a transfusion of blood from her husband in another hospital a year previously. Her blood was group A, as was that of her husband. On March 14th another transfusion of 500 c.c. of group A blood was followed, in about an hour, by a chill lasting eight minutes. No hemoglobinuria was noticed. Her temperature rose to 101°, but had been elevated on previous days. On March 16th another transfusion of 500 c.c. of blood was followed by a chill which lasted twenty minutes. There was also nausea. On March 21st icterus was noticed and thought to be related to her abdominal condition. On March 23rd another transfusion of 500 c.c. of apparently compatible blood was followed by a chill. On March 25th another transfusion was given without chill, though her temperature rose above the level of the previous day. On March 31st transfusion was started at 10:20 A.M. and run in quite slowly. At 11:10 a chill began and the transfusion was stopped. No evidence of hemolysis was seen. On April 13th a transfusion of 500 c.c. of group 0 blood, which was Rh negative, was given without any evidence of reaction. We had by this time recognized that this patient was Rh negative, and found that she had anti-Rh agglutinins in her blood. On April 22nd a transfusion of group 0 Rh negative blood was started. After twenty minutes, when about 200 c.c. had been given, the patient complained of severe pain in the spine. The transfusion was discontinued. About one-half hour later she had a chill and her temperature rose to 105°, but no hemolytic phenomena developed. The cross agglutination between the patient's serum and the blood given her at this time was done for one hour in the water bath and was entirely without evidence of agglutination. On April 25th she was given 500 c.c. of group A, Rh negative blood without evidence of reaction. After this very stormy course, both from the surgical and the transfusion standpoint, she improved, left the hospital and is now quite well. Her anti-Rh serum titre, which was high at the time she left the hospital, had by November, 1942, decreased until it was difficult to demonstrate anti-Rh agglutinins in her blood. Her husband was found to be Rh positive, but opportunity to test for the Rh property in the other early donors was not afforded. It is interesting to note that no erythroblastosis,

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* Read before the Section on Pathology and Bacteriology, at the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

given her at this time was done for one hour in the water bath and was entirely without evidence of agglutination. On April 25th she was given 500 c.c. of group A, Rh negative blood without evidence of reaction. After this very stormy course, both from the surgical and the transfusion standpoint, she improved, left the hospital and is now quite well. Her anti-Rh serum titre, which was high at the time she left the hospital, had by November, 1942, decreased until it was difficult to demonstrate anti-Rh agglutinins in her blood. Her husband was found to be Rh positive, but opportunity to test for the Rh property in the other early donors was not afforded. It is interesting to note that no erythroblastosis,

jaundice, apparent anemia or miscarriage occurred in her nine pregnancies. Only her oldest child was examined in the laboratory, and he was found to be Rh positive.

* * *

Case 3.—M. A., male, age 48. Entered the Hospital of the Good Samaritan, October 6, 1942, with a diagnosis of carcinoma of rectum. His red blood count was 3.9 million, his hemoglobin 68 per cent, his blood group A, his temperature normal. On October 7th he had a transfusion of 500 c.c. of compatible group A blood followed by a chill and temperature of 102°. On October 12th another transfusion of 500 c.c. was followed by rise of temperature to 102°, but there was no chill. The temperature, the previous day, had reached 101.6°. On October 14th the red blood count was 4.7 million, hemoglobin, 71 per cent, leucocytes, 4,200 with 22 per cent unsegmented neutrophiles and 54 per cent segmented. On October 16th an abdomino-perineal resection of the carcinoma of the rectum was done. A transfusion was given during surgery without incident. Another transfusion of 500 c.c. was given October 17th without reaction. On October 21st, blood count revealed red blood cells 4.2 million, hemoglobin, 72 per cent. The patient recovered from his operation, but during his stay in the hospital he had some fever, often to 101° and occasionally to 102°. On November 24th his count was red blood cells 3.3 million, hemoglobin, 54 per cent. He had a 500 c.c. transfusion as an out-patient on December 12th. No reaction was reported, and the hemoglobin rose to 72 per cent. On January 22, 1943, he again had a transfusion as an out-patient and, following this, had a chill and nausea. No hemoglobinuria or jaundice was noticed, but there was no rise in red blood cells or hemoglobin. On January 26th another transfusion was given, this time by the multiple syringe method at the request of his physician. Cross matching by hanging drop method was satisfactory. No discomfort was experienced during the transfusion, but about one-half hour later he had a severe chill and vomited. The first urine passed contained hemoglobin, and blood serum taken at that time evidently contained hemoglobin. Since he was an out-patient, he went home. The next day an oliguria was noted and there was a slight icteric tint to the sclerae. The vomiting continued, so he was brought to the hospital on January 28th and given intravenous glucose and sodium lactate. His urinary output the first 24 hours was 550 c.c. His blood NPN was 135. We have no record of a previous NPN. His vomiting was controlled in a short time, and his urinary output rose rapidly on forced fluids until he was putting out as much as 4,000 c.c. daily. The specific gravity was low on admission and remained low while fluids were forced, but a specimen on February 25th had a specific gravity of 1.015. During his stay in the hospital he was given five 500 c.c. transfusions of Rh-negative blood without incident, except in one case where he had a chill following the transfusion but no hemolytic phenomena. A test dose of 50 c.c. of this blood was given, several hours before the remainder of the 500 c.c., without reaction. On another occasion a test dose of 100 c.c. of Rh-negative blood resulted in a chill, so he was not given the rest of this blood. The remainder of this blood (300 c.c.) was given to another patient and produced no reaction. In spite of these transfusions his blood count showed only transient improvements, and his hemoglobin remained around 50 per cent. This patient died rather suddenly February 26th with evidence of cardiac failure, and on autopsy was found to have a subacute bacterial endocarditis, with rupture of the chordae tendineae of the aortic cusp of the mitral valve. In the kidneys there was damage incident to the bacterial endocarditis, but there was not much evidence of the nephrosis which must have been present at the time of the oliguria. Blood taken following the transfusion on January 26th was found to be Rh negative, and the serum was found to contain strong anti-Rh agglutinins. This is contrary to the findings reported by others. Transfusion of Rh-positive blood usually causes absorption and temporary disappearance of the agglutinins. The donor used at this time was found to be Rh positive. Only one donor used previously was available for study. This one, used October 12, 1942, was found to be Rh positive. Serum taken December 12, 1942, was found in the refrigerator and was tested on January 27, 1943. It contained less strong but definite anti-Rh agglutinins. No doubt the reaction following the transfusion of January 22nd should have aroused our suspicions, and caused us to investigate the Rh status of the patient, but it occurred after the patient left the laboratory and was not observed.

COMMENT

It is evident that grouping and ordinary cross matching, with the employment of an apparently compatible donor, does not always insure a safe transfusion. Certainly when transfusion of a woman during pregnancy, or immediately following termination of pregnancy is necessary, the possibility of the presence of antibodies against the Rh factor should be considered, and compatibility tests should be conducted with this in mind. The same is true when multiple transfusions are given to any individual.

We know now that the Rh factor is more complex than was at first thought, and that there are at least two subdivisions of this antigenic factor,[4] perhaps analogous to the subgroup A_1 and A_2. Some testing sera, that is, sera from patients who have developed anti Rh agglutinins, may react strongly with an Rh_1 blood and not with an Rh_2. It is unsafe, therefore, to test a patient with a single human test serum and report him Rh negative. The preparation of Rh antisera by immunization of animals is not easy. Rhesus blood is used and monkeys are not available in every laboratory. Only a small proportion of animals injected will furnish a potent antiserum. I know of only one antiserum on the market, and our experience with it has been disappointing. Cross agglutination for transfusion, when the presence of Rh antibodies is suspected, should be carried out at body temperature in tubes, in the water bath for one hour; or after water bath incubation for fifteen minutes the tubes may be centrifuged at low speed for one minute and the same result obtained. One drop of 2 per cent suspension of washed donor's cells is added to two drops of patient's serum. It is now my practice to use this method of cross agglutination in all transfusions of intrapartum or postpartum women, and in all multiple transfusions of other individuals. that is, in all individuals who have previously received one or more transfusions, unless it has been possible to prove with certainty that the patient is Rh positive. Even this method of cross agglutination may not prevent all hemolytic reactions, since demonstrable antibodies may not be present in the blood when they are present in the reticulo-endothelial system. However, it probably will prevent all serious reactions. It is, of course, essential to use an Rh-negative donor in transfusing a patient known to be Rh negative.

Undoubtedly, there are other factors which may produce hemolytic reactions. The P factor apparently has been an offender. Transfusion of A_1 blood into an A_2 patient has been known to stimulate production of agglutinins for A_1 cells. Very rarely other factors, their nature as yet undetermined, may be operative. However. all of these are unimportant as compared with the Rh factor.

SUMMARY

The importance of the Rh factor in the production of hemolytic transfusion reactions is discussed. Three illustrative cases are reported. Methods for prevention of the reactions are considered.

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CHEESE-BORNE EPIDEMICS OF TYPHOID FEVER*

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DURING the months of April and May the California State Health authorities were greatly baffled by an increased incidence in four counties of typhoid fever (77 cases, resulting in 2 deaths, and 6 cases in Nevada, all due to the same type—Type C—Eberthella typhosa).[1] Painstaking and diligent epidemiological inquiries into the various articles of food which could have acted as vehicles for the infective agent disclosed that, common to all cases, was the consumption of unpasteurized Cheddar cheese of the unripened variety (Romano-dolce, Teleme, or high moisture (57 per cent water) Monterey Jack). Inductive evidence incriminated the uncooked cheese, since invariably the members of the families who were consumers of large quantities were affected, while those who consumed it in the cooked form were not attacked. At first, considerable doubt was cast on the interpretation of these epidemiological facts, since even in professional circles the belief still lingered that "the chances of typhoid infection from this dairy product are considered very slight" (L. L. Lumsden)[2]. Fresh cream cheeses, such as cottage cheese, may be responsible for an occasional case or small outbreaks such as reported by *Graham Stewart and his associates*[3] who traced a paratyphoid epidemic of 23 cases to an Italian cream cheese. A full cream cheese of short cure, prepared from milk on a farm where a typhoid carrier was employed, and probably between 9 and 30 days old at the time of retailing, caused 51 cases and 4 deaths in Michigan (Rich, 1923)[4]. Semihard cheese of the limburger variety was apparently responsible for 108 cases and 5 deaths in a small town in Germany; how the cheese became infected was not determined, but the epidemiologic evidence suggests the probability that it became contaminated in the store by an ambulatory case of typhoid fever, and the relatives who subsequently served as nurses (Sorge, 1924).[5]

OTHER EPIDEMICS

In recent years, our good neighbors in Canada have had their share of typhoid fever caused by hard rennet cheeses of the Cheddar variety. As early as 1932 an outbreak of 627 cases, with 57 deaths occurred in the St. Maurice Valley (Foley).[6] At least 5 additional outbreaks are on record (Dolman)[7] for the period 1932 to 1939, and since 1942 five more must now be added.

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* From the George Williams Hooper Foundation for Medical Research, University of California Medical School, San Francisco.

Three epidemics, involving 100 cases ascribed to the eating of contaminated cheese, have been described by Bowman.[8] A raw-milk supply from a farm operated by a typhoid carrier was suspected as the most likely source of the contamination. In the 1941 outbreak, in the country of Champlain, Gauthier and Foley[9] there were 40 cases, and 6 deaths (due to phage type D1). The cheese responsible for the infection was traced to a factory, which received raw milk collected from the cows by a chronic typhoid carrier. The typhoid bacilli isolated from the woman were identical in the phage test with the cultures obtained in the epidemic. More recently, in 1944, another 80 cases, with 6 deaths were observed in the Province of Alberta. A carrier was discovered in the milk-shed supplying the Cheddar cheese factory.[10]

Already, in 1925, Wade and Shere[11] investigated an epidemic of 29 cases of typhoid fever with 4 fatalities in Minnesota. The evidence proved a carrier in the family of one of the contributing patrons of the cheese factory as the source of infection. As the creamery had many requests for the fresh cheese, the product was distributed as early as 10 days after making, instead of holding it to ripen as is usually done. Epidemiological data, furthermore, showed that the typhoid bacilli had lived in the cheese approximately 63 days. At least two cheese-borne epidemics of typhoid fever have been observed in New York State. In the most recent outbreak, described by Schlesinger,[12] 23 cases of typhoid fever were probably due to the ingestion of curd, or fresh cheese, at a local factory. Among the dairy farmers supplying the cheese factory a typhoid carrier, harboring the same type of typhoid bacilli (Type C) as demonstrated in the patients, was discovered. Finally, according to a preliminary report[13] Indiana experienced in 1944 a typhoid epidemic of 225 proved cases and 12 deaths traceable to the eating of green cheese made from unpasteurized milk.

THE INFECTIVE AGENT

All the evidence on cheese-borne typhoid fever, incomplete as it is, and intriguing as it becomes when subjected to a biological analysis, shows, however, one common denominator: the infective agent invariably reached the cheese through the use of *raw* milk accidentally contaminated by a carrier or an ambulatory case. Adequate pasteurization of the milk, or pasteurization at any stage in the cheese making process, should render fresh, unripened cheese safe. However, the consumer, and consequently the industry, continue to argue as to whether or not the acceptable flavor is destroyed or the quality and consistency are injuriously affected by heating of the milk. It is rather surprising that no reliable data are available to support the arguments of either side. From the standpoint of public health there is only one way to render the cheese safe, and that is by pasteurization. Other means have been suggested in order to preserve flavor and quality of the Cheddar cheeses. Since ripening requires weeks or several months in order to bring about the changes characteristic for the cheese, it has been stated that cured cheeses of the Cheddar type are safe if they are held in storage for 1 or 2 months. These conclusions are based on the studies of Wade and Shere, who showed that in artificially-infected cheeses held at 60° C. the typhoid bacilli lived for from 34 to 36 days.

Less encouraging are the interpretations which must be given to studies by Campbell and Gibbard[14] who found in experiments that with a contamination of from 1,000 to 600,000 typhoid bacilli worked into cheeses, viable infective organisms were retained for a period of *3 months* when held at 58°-60° F. At lower temperatures of 40-42° F., the typhoid organisms could be isolated for 6 months and, in fact, in the majority of the cheese specimens, for 10 or more months. One could argue that a contamination of the same magnitude, as chosen by the two experimenters, rarely occurs under natural conditions. This is doubtless true. On the other hand, the experiments leave little doubt that the manufacturer of Cheddar cheese cannot depend on the acids or on the antibiotic forces liberated by the ripening process to free his product from disease-producing microörganisms.

CALIFORNIA PROCEDURES

In view of the overwhelming factual evidence that fresh, unripened, soft, Cheddar cheese may occasionally produce typhoid fever, steps were immediately taken in California to remove the suspected lots of cheeses from the market. Furthermore, an act to amend Sections 540 and 547 of the Agricultural Code was passed by the Legislature in special session. In future, all cheese sold in California to the retail trade must be pasteurized or manufactured from milk which has been pasteurized, except cheese which has been allowed to ripen or cure for a minimum of 60 days from the date of manufacture. As a further protection, all cheeses in California must be labeled as to date, place of manufacture and grade.

In taking these drastic steps without delay, the two State Departments—Agriculture and Health—entrusted with the safeguard and welfare of the people, have had the sincere and complete coöperation of the dairy and cheese industries. They have likewise enjoyed the expert counsel and advice of the far-sighted leaders of the respective industries. During wartime, cheese is an exceptionally important article of food, furnishing animal proteins at a low cost. Grave consequences had to be anticipated by curtailing the use of this commodity. Without the highly intelligent coöperation of everybody concerned, and without the fullest appreciation of the manifold human relationships, the highway on which the progressive Public Health Services of California have recently advanced could have been damaged by unforgivable blunders.

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OCCUPATIONAL ADJUSTMENT OF THE DISABLED*

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THE feasibility of successful occupational adjustment of the disabled to industry is an accomplished fact. For 23 years the Bureau of Vocational Rehabilitation, State Department of Education, operating with Federal and State funds, has provided an adjustment service for the express purpose of making handicapped persons employable. In that period approximately 20,000 physically-impaired men and women in California have been prepared for and placed on suitable jobs. Included in the number are persons injured in industry or otherwise; persons with defective vision or hearing; persons handicapped by tuberculosis or by heart impairments; and young persons crippled by poliomyelitis or congenital defect. In short, any person of employable age (16 years or over) who has an employment handicap by reason of disability is eligible for the service, regardless of cause or nature of the impairment.

MEDICAL RELATIONSHIPS OF REHABILITATION PROGRAM

It is obvious that such a service should be of interest and concern to the medical profession, and especially to those who specialize in industrial medicine and surgery. Vocational rehabilitation is dependent upon the physician for maximum physical restoration involved in occupational adjustment; vocational rehabilitation in turn may supplement or complement your work by providing vocational services needed by the patient that you are not in a position to provide. We have had years of experience in within-plant adjustment and readjustment of the handicapped; in placing handicapped workers where they will not be a hazard to themselves or to fellow-workers; in placing them where their abilities can be used to the best advantage of the employer.

Until 1943, the services offered were counseling or guidance, vocational training, transportation, provision of prosthesis if needed, and aid in placement. In 1943, amendments to the Federal Rehabilitation Act broadened the scope of the program by making available to those "found to require financial assistance with respect thereto" the following additional services:

Corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical condition which is static and constitutes a substantial handicap to employment, but is of such a nature that such correction or modification should eliminate or substantially reduce such handicap within a reasonable length of time.

Necessary hospitalization, in no case to exceed ninety days, in connection with surgery or treatment specified in subparagraph next above.

Maintenance not exceeding the estimated cost of subsistence during training.

At the same time the definition of Vocational Rehabilitation was liberalized to mean "any services necessary to render a disabled individual fit to engage in a remunerative occupation." The term "disabled" was interpreted to include the mentally-handicapped as well as the physically handicapped. Thus, the Bureau now has a complete and comprehensive program designed to meet the needs of any disabled person in his or her occupational adjustment.

The Bureau also has a staff of 60 experienced rehabilitation experts working out of three district offices at San Francisco, Los Angeles and Sacramento, and 13 branch or local offices, thus covering the entire State.

OPERATION OF PROGRAM

The operation of the program is simple in statement, although often difficult and complicated in practice. On the basis of a thorough survey of the individual including, of course, medical diagnosis, his vocational assets are evaluated, his adjustment needs determined, and a plan prepared to meet those needs. Counseling or guidance is obviously of paramount importance in such a program. Consideration of the needs of the applicant starts with an individual diagnosis or analysis of all the factors involved. On the basis of that diagnosis there is selected a job objective or employment goal. The prerequisites of that job objective are checked against the individual's deficiencies and potentialities to determine the necessary services to be provided by vocational rehabilitation to enable him to engage in the chosen work; those services are then provided. That is the emphasis; a controlled, purposeful, individualized program of services to achieve a specific employment goal. That is what makes vocational rehabilitation constructively different.

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* Read before the Section on Industrial Medicine and Surgery, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

From the Bureau of Vocational Rehabilitation of the California State Department of Education.

Re: Special C.M.A. Advisory Committee on Vocational Rehabilitation, see Council Minutes of October 10, 1943 (CALIFORNIA AND WESTERN MEDICINE, for November, 1943, Item 7, page 274).

The first thing we look for is the possibility of physical restoration or improvement. Will surgery or other therapeutic treatment remove or lessen the employment handicap? Will prosthesis make the individual employable? Next, does the applicant have marketable skills or abilities that make possible placement on a suitable job without special preparation. If not, vocational training is usually indicated.

Training may be provided on any level and in any field. The best available facilities are used, including public or private vocational, commercial or technical schools, or on a higher level, junior colleges, state colleges and universities. Employment or "on the job" training is sometimes the preferred method. Correspondence course or tutorial instruction may be used to supplement other training. We have successfully prepared disabled clients for more than 400 different occupations.

Returning to the physical restoration program, it is not the intention to engage in state or socialized medicine. In the first place, such service will be provided only to those in financial need who would otherwise be deprived of remedial treatment. Next, no person is eligible who is also eligible for similar service from another source. Again, the distinction is sharply drawn between acute and static conditions, only the latter being considered.

Assistance in establishing the policies and standards under which the service will be offered is a function of a Medical Advisory Committee appointed on nomination of and in consultation with the California Medical Association. A similar Committee on the national level includes a representative from California, namely, Karl M. Bowman, M. D.

To insure adequate operation of the program there will be appointed on the Bureau staff at least one Medical Consultant, two Supervisors of Physical Restoration and two Medical Social Workers. There will be selected panels of physicians, including specialists in the various fields of surgery and medicine, to whom cases will be referred for treatment. The matter of a fee-schedule satisfactory to the California Medical Association and to the Bureau is being given special consideration. We are making every effort, with the aid of the medical profession, to make this new phase of our vocational rehabilitation program a scientific, practical, and medically-respectable service, matching or even surpassing the effectiveness of the other services we have rendered to the handicapped over the years.

It would seem that closer coördination between industrial medicine and vocational rehabilitation would be mutually advantageous, and particularly would be beneficial to the group of injured or otherwise disabled workers with whom we are both concerned. It is true that in many industrial accident cases your skill promptly restores the injured worker to normal physical condition; he returns to his former job, and vocational rehabilitation does not enter into the picture. But it is also true that in other cases there is residual disability that may bar the injured worker from his former job, or perhaps from any other job his former employer has to offer. Occupational adjustment becomes essential; the staff of the Bureau of Vocational Rehabilitation are experts in this field; their services are at your disposal. If the injured worker needs vocational guidance, we can provide it; if he needs training for a new job, it can be made available; we can aid in his judicious placement.

It may sometimes be possible for our Bureau to supply vocational information or advice to assist you in the determination of treatment or disposition of a particular case. After all, industrial medicine does not function in a vacuum; its vocational implications impinge upon our field.

REPORT OF CASES

Case 1.—In one illustrative instance, a young man had sustained an injury to a knee which necessitated permanent immobilization of the joint. The surgeon had the option of position of fixation and faced the problem of making a decision. He wisely felt that the nature of the patient's future work should be the controlling factor, but the patient's previous work experience and his lack of any definite employment goal afforded no clue as to a suitable job objective. Again acting wisely, we believe, the surgeon called upon our Bureau for vocational advisement. Our counseling procedures, including the administration of a battery of intelligence and aptitude tests, clearly indicated that the patient could not profitably follow desk work or other work performed in a sitting position, but that electrical bench work fitted very well his abilities, skills and interests. The knee was therefore immobilized in the extended position. The Bureau provided the necessary training, and the man is now successfully employed on a highly-skilled job where he not only receives an excellent wage but also is contributing to the war effort.

* * *

Case 2.—In another case, a young man with an atrophied and entirely useless leg found that his crutches barred him from employment. He consulted a surgeon who advised him that amputation and an artificial leg would solve his problem. The boy expressed some reluctance and stated that, in any event, it was impossible because he had no funds either for the operation or for the appliance. The surgeon sent him to our Bureau. We told him that not only would the State take care of the necessary cost, but we would also provide training and assure him placement on a suitable job. He, too, is now happy on a war production job, and finds his new leg far more satisfactory than the useless old one. He donated his crutches to a welfare agency for the use of someone less fortunate than himself.

COMMENT

At the Fifth Annual Congress on Industrial Health, Chicago, 1943, it was stated that industrial surgeons should use their influence with management to establish a more scientific method of placing workers in industrial plants, and a more receptive attitude toward the employment of the handicapped, using proper rehabilitative procedures. This was coupled with the proposal that the medical profession, the workmen's compensation agencies and rehabilitation officials, appoint committees to get together on a program in respect to the problems in which we have a common interest. That proposal would seem to be just as logical in California as on the national level. For our part we offer our coöperation and every assistance we can give to such a movement.

In a recent article, John Bart Lauricella, M. D., President, Section of Industrial Medicine and Surgery, Pan American Medical Association, pays a tribute to Vocational Rehabilitation in summing up how that service may supplement medical treatment. He says:

"It is indeed fortunate for the industrial worker, as it is also for society, that trained lay experts have been attracted to this most important field of social welfare. Without them, the job of the surgeon would be but half-done, and probably would fall far short of any real accomplishment. Without them, the painstaking efforts of the doctor might prove to be in vain. To them we owe much for the diligent manner with which they view their jobs—for their great patience with these most troublesome cases—and for their noble and painstaking efforts, perseveringly applied until a satisfactory or optimum result is obtained." (National Rehabilitation News, January, 1944.)

We shall try to live up to Dr. Lauricella's encomium, and we place at your disposal our every aid in the common problem of occupational adjustment of the disabled.

California Bureau of Vocational Rehabilitation.

TREATMENT OF ACUTE NAVAL CASUALTIES*

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Mare Island

On August 9, 1942, without advance warning, over two hundred acute naval casualties were received aboard the U.S.S. ——— in a period of about two hours. These patients were suffering from injuries received in the first Savo Island naval engagement. They were transferred aboard the vessel from destroyers which had, within the previous six or seven hours, rescued them from sunken or damaged ships. Many of these patients had spent from four to six hours in the water, held afloat by their life preservers, wreckage, or small rafts. At the time they were picked up by the destroyers, treatment was rendered the most severely wounded. This usually consisted of the injection of one-half grain of morphine and then the first-aid care of their wounds. The wounds were simply sprinkled with a sulfa drug and a sterile gauze dressing applied. Fractures were immobilized by leaving the patient on the deck and fixing the extremity in as comfortable a position as possible. There was no time for the administration of blood plasma.

We also received aboard nineteen Japanese prisoners, nine of whom were injured survivors from planes which had attacked us the previous day, and of which six were suffering from burns of various degrees, but chiefly of the hands and face; their aviation dress and helmets having provided adequate protection for the major portion of their body and extremities.

The medical organization aboard the U.S.S. ——— consisted of three medical officers and thirteen corpsmen. Four additional medical officers, and eighteen additional corpsmen came aboard with the wounded, as uninjured survivors. In preparation for such emergencies three operating theaters had been prepared, and one of the ship's medical officers was assigned to each. In this emergency, however, and in view of the fact that additional medical personnel were also received, the senior medical officer took charge of the general assorting and distribution of the wounded, corpsmen's details and other administrative problems; another medical officer was assigned to supervise the general and supportive treatment; and the remaining medical officers were divided between the three surgeries.

HOW PATIENTS WERE GROUPED

The patients were grouped roughly into three classes: (1) gunshot wounds of the soft tissue; (2) compound and simple fractures; and (3) burns. The order of treatment was adjudged according to the urgency required, and the beneficial effect expected. Although one station had been reserved primarily for the treatment of burns and another for fractures, due to the fact that 84 per cent of the wounds received were caused by metal fragments, involving various degrees of soft-tissue damage, the three operating theaters were all handling this type of injury.

We received thirty-one burns, most of which were first and second degree; eleven compound and six simple fractures; one hundred and sixty-one patients with wounds involving the soft tissue only, most of which were multiple; one penetrating wound of the abdomen, and one penetrating wound of the chest.

Burns were treated by the application of tannic acid jelly, followed with a covering of cellophane; and over this was applied a dry gauze dressing. Burns about the face were treated only by the application of tannic acid jelly, and left exposed.

Soft tissue wounds were first cleansed with soap and water, and then lavaged with saline, debrided, and the metallic fragment if accessible removed. This was often found to have carried in with it portions of clothing and kapok which also required removal. A few of the soft-tissue wounds were at first closed loosely with interrupted nonabsorable suture; but this soon proved impractical because of the length of time from the primary injury We therefore simply relied on superficial debridment, local application and daily oral administration of a sulfa drug, packing the wound with plain gauze and a gauze dressing. Later all wounds that seemed would be better immobilized were redressed and incased in plaster, and were not again dressed.

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* This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the U. S. Navy. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the Navy Department, or the military service at large.

The soft-tissue wounds of compound fractures were treated the same as other soft-tissue wounds. The metallic fragments were usually more difficult to locate, and x-ray films were frequently taken. Particular care was exercised in removing any foreign material or detached bone fragment which would later become necrotic and lead to bone infection. Wounds were sprinkled with sulfanilamide or sulfathiazole, packed loosely with plain gauze, and immobilized in plaster. In fractures of the leg and lower portion of the femur, the pin-and-plaster technique (placing a through-and-through pin proximal and distal to the fracture and incasing the extremity in plaster) was used, when possible. We were fortunate in having a mechanical reduction apparatus aboard, and this proved invaluable in the treatment of fractures which could be immobilized by this method. Fractures of the lower extremity, in which plaster fixation was not applicable, were immobilized in fixed skeletal traction, using a Thomas leg splint.

The treatment of simple fractures was delayed for about three days because we felt that these could wait without harm, and it gave us an opportunity to devote our attention to those requiring more urgent care. Here, again, the pin-and-plaster technique was employed with excellent results.

All the wounded patients received oral sulfathiazole medication, which was continued for the five days they were aboard. Morphine in one-half grain doses was administered freely. At first we had planned to keep a record of the frequency of the injections given, but in the rush we found this impractical. Our criterion for repeating the dose was purely the clinical appearance of the patient. In one instance, in which an apparent over-dose appeared to have been given, it seemed to work to the clinical improvement of the patient. Plasma was used freely in both shock and in marked blood-loss. We found the liberal use of morphine our most valuable aid in combating shock, and felt that our results from the use of plasma were not as dramatic as we had expected. It seemed to have no beneficial effect in those who had suffered profound blood loss, and did not compare favorably with morphine in the treatment of shock. For marked blood-loss, whole blood transfusions were later given with definite beneficial effect; but for the first three days we did not have time for this procedure.

We received no patients suffering from penetrating wounds of the skull, and only one each of the chest and abdomen. The patient with the abdominal wound, died later despite an exploratory laporatomy. The absence of such cases can be explained by the fact that most of those who had received these wounds did not live long enough to be rescued and brought aboard, and explains our high percentage of extremity and soft-tissue body wounds.

At first, ether was used for anesthesia; but we soon found sodium penothal equally effective, much more convenient, more rapidly administered, and associated with a much more favorable postoperative reaction. In minor cases, no anesthetic was required in addition to the one-half grain doses of morphine which was administered preoperative. Although most of the patients were suffering from multiple fragmentary wounds, most of the fragments could be easily found with a probe, grasped with a strong forceps and removed without much discomfort. Many of the fragments were lying partially exposed in the wound, and were not deeply imbedded. It was not unusual to remove five or six such fragments from one individual. The fragments varied in size from very small specks to pieces about six inches in length. All were very irregular, and their edges were usually quite sharp. These wounds were usually fairly clean, did not show much evidence of the tissues being devitalized, unless the wound was extensive, and thus, as a rule, required only very minor debridment. The cleanliness of the wounds was due to the fact that they were produced by clean metallic fragments, and had no opportunity for soil contamination. Some, however, in those who had been rescued from the sea, had their wounds contaminated with a dark oily skum; but unless the tissues were definitely devitalized, no extensive debridment was undertaken. Such wounds were simply sprinkled with a sulfa drug and packed with gauze.

Most of our second, and all of our third degree burns showed some evidence of superficial infection by the fourth day. In no case was an eschar produced by the use of tannic acid jelly. It produced a brown discoloration of the skin, acted as a clean protective medication, and facilitated redressings, but did not seem to protect the burned area from infection. The cellophane, in numerous instances, became adherent to the wound, and made redressings very painful. It was not perforated, and thus did not allow sufficient escape of the fluid accumulation. We were not impressed by our treatment of burns.

Our patients were all transferred on the fifth day and, therefore, we had not had them under observation long enough to properly evaluate our methods of treatment. By the fourth or fifth day, most of the extensive wounds, in which we had thought it not advisable to do anything other than sprinkle with a sulfa drug and protect with a gauze dressing, were showing evidence of infection and necrosis of devitalized tissue. In many of these the sulfa drug had been applied in excessive amounts and had formed what appeared to be an irritative foreign body. At least the presence of the sulfa drug, in large amounts, seemed to have no influence on the extent of superficial wound infection in the presence of necrotic tissue. Most of the other wounds looked good, but we felt that probably a high percentage of these would later show evidence of at least superficial infection. It was surprising to observe the rapid clinical improvement occurring in the first three days. Most of our bed patients had by then become ambulatory, especially those with injuries involving the upper extremities, and the need for morphine showed a marked decline. Only those who were severely injured still showed any evidence of shock. Despite the large number of wounded and the extent of their wounds, we had no psychological problems.

Plaster of Paris was used freely. Wounds of any great size were immobilized, either by splints or light circular casts, whenever possible. This added greatly to the comfort of the patient and, we believe, must have hastened the wound-healing.

COMMENT

Of the sixteen patients who died, all but one expired in the first forty-eight hours, and over one-half in the first twelve. Most of the deaths were due to multiple fragmentary wounds with severe loss of tissue and profound shock. In only one was operative treatment given, it not being felt that it would be of value in the others. No amputations were performed, but two traumatic amputatoins of a major extremity were received. One had a disarticulation at the knee and was in such deep shock that no further surgery was attempted; and despite supportive treatment including large doses of morphine and three units of plasma, the patient expired in a few hours.

Since many of the wounded had been rescued with difficulty, facilities for treatment very limited, and the hazards and suffering which they had to go through, before being received aboard easily explains why many were not in physical condition to withstand further handling. The relief from pain and the associated shock were considered the most urgent. No radical procedures, therefore, were undertaken, nor was any elective reconstructive surgery attempted. Except for a few instances, first-aid surgery was all that we felt it advisable to do.

We received aboard several hundred non-wounded survivors, in addition to their medical personnel already mentioned. These proved invaluable in helping us render aid to the wounded. Many freely volunteered their services, and thereby greatly relieved the available hospital corpsmen. It should also be mentioned that these same members of the ship's company had been responsible for the saving of many lives prior to being received on board. During the naval engagement, the casualties occurred so rapidly that no medical personnel could possibly have been so omnipresent as to be available to treat them all. Time, the compartmentation of the ship, the rapidity of the casualties, the rapidity in which the ships sank, the darkness, and many other factors made it necessary that the uninjured survivors render first aid to their own wounded if any was to be given. For this reason it is felt that the importance of the knowledge of first-aid among the members of a ship's company should be widely understood, and that it is paramount that they receive adequate and repeated instruction in at least the principles involved.

IN CONCLUSION

Although it might appear that one cannot do justice to such a large number of acute casualties in such a short space of time, we were greatly impressed by the rapid general clinical improvement which occurred in the first five days that they were aboard, and we feel that most of this improvement was due to recovery from their primary shock, and that it was too early for any toxemia to have developed from a severe infection. We were also impressed by the result obtained by conservative surgery, namely, not attempting anything that would add greatly to the shock of an already severely shocked patient, until adequate recovery had occurred. Most of our injured were compelled to lie on the deck on a stretcher until they were taken to surgery, and from there placed in their respective bunks. This delay, in most instances, was not harmful. They were not excessively handled, their complaints were given attention, sedation and oral fluids were administered freely, and much needed rest and nourishment was provided; and these factors we feel were largely responsible for any of the beneficial results obtained.

U. S. Naval Hospital.

FOOD POISONING DUE TO CUSTARD FILLED PASTRY: REPORT OF OUTBREAK

CAUSATIVE ORGANISM, B. TYPHI-MURIUM

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and
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Within a six-day period, from March 24 through March 30, 1944, there were reported 69 cases of food poisoning in San Francisco. The symptoms were vomiting, nausea, diarrhea, with chills and often fever. The onset period varied from three to seven hours after the suspected food was consumed.

Fifty-one of the persons afflicted partook of food at a church dinner, and the remaining eighteen were from six unrelated families residing in different residential areas of the city. All except one case gave a history of having eaten custard-filled eclairs. Epidemiologic investigation disclosed that all of the pastry was purchased from bakery "A." This firm manufactures all products in a central plant, and distributes through nine retail stores, six of which were outlets for the contaminated food involved in this outbreak.

All case histories definitely indicated that the causative food was purchased on March 22, 1944. The first case of illness was reported during the late afternoon of March 24th. The late reporting precluded the possibilities of obtaining specimens of the causative materials or stool specimens from victims. There were, however, two exceptions: a custard-filled eclair had been taken home by one of the persons who had attended the church dinner. The laboratory examination of the eclair was negative for food poisoning organisms; coli-aerogenes group confirmed. Secondly, among the groups reported, the "D" family had six children, five of whom were hospitalized in the Isolation Division of the San Francisco County Hospital of the Department of Public Health. The laboratory examination of feces of all five was positive for B. typhi-murium, but the findings on the rodent feces or droppings collected in the central plant were negative.

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* From the Department of Public Health, San Francisco, California.

The negative findings for food poisoning organisms in the one recovered eclair, and the fact that all retail outlets of Bakery "A" were not involved, were typical of the spotty distribution of infection of the food, commonly found in such cases. Bakery "A," however, had been involved in previous minor outbreaks over a period of several years, the infected organisms isolated being hemolytic staphylococcus aureus.

Bakery Sanitation:

The general sanitation of bakery "A" was found to be good. Working methods, however, were not satisfactory. A tremendous increase in production, and insufficient and untrained workers were the obvious reasons for carelessness, most noticeable in the scullery department. The Department of Public Health has certain regulations governing sterilization of utensils, cooking of the custard (boiling for a minimum period of five minutes), cooling (to 45° within 30 minutes), proper refrigeration, personal hygiene and clean clothing of those engaged in the preparation and handling of the product, transportation and protection of the product until its ultimate sale.

Bakery "A" was complying in all but several features of the regulations. These, however, were the most important: cleanliness of utensils, rapid cooling and proper refrigeration. Investigators found gross negligence in the washing and storage of baking pans and pots. After washing in an unsatisfactory manner, this equipment was so stored as to be readily contaminated by flies, dust or rodents, and rat infestation was demonstrated in the storage room.

The custard was prepared at 6:00 a.m., poured into shallow pans and allowed to cool at room temperature until 10:00 a.m., at which time it was processed into eclairs, puffs and cakes. The mix consisted of one gallon of water (16 oz. of powdered milk added), 2 lb. of sugar, 12 oz. of cornstarch, 16 egg yolks (fresh), salt and vanilla flavoring. The slow cooling process provided ideal temperature for optimum growth of any toxin-producing organisms, if specific bacteria had contaminated the pans prior to the custard being poured therein, or the custard mix itself during the cooling period.

From the epidemiologic investigation and the laboratory findings of B. typhi-murium in stool specimens of five patients, plus evidence of rodent infestation in Bakery "A," it was concluded that the custard from bakery "A" made on March 22, 1944, was the causative food. Either the custard itself was directly infected while cooling, which was not unlikely, or it was indirectly contaminated through the pans used and their improper cleansing.

It is customary for bakers in San Francisco to manufacture custard products practically every day of the year. The 22nd day of March, 1944, was quite warm, the temperature having reached a maximum of 72°, which is well above normal.

For the past several months, samples of commercially-prepared custard products from different sources have been examined at weekly intervals. The *p*H is determined and bacteriologic examination for organisms of the food poisoning and coli-aerogenes groups is made. If any of these bacteria are found, an inspector immediately visits the factory, and endeavors to locate and eliminate the source. Utmost coöperation has been afforded by the entire industry. Efforts are being made to inform all consumers by labeling packages with a statement that the article is perishable and should be under refrigeration until ready to serve.

In such findings on 50 specimens, the *p*H varied from 3.98 to 6.85, the average being 5.98; coli-aerogenes group was confirmed in 13 specimens; coli-aerogenes group and nonhemolytic staphylococcus aureus were found in 9; coli-aerogenes group and hemolytic-staphylococcus aureus in one; and nonhemolytic staphylococcus aureus in one. The remaining 26 were negative.

DISCUSSION

Sixty-nine cases of illness from contaminated custard eclairs were reported to the San Francisco Department of Public Health within a period of six days. Fifty-one were from one church dinner group, the remainder from six unrelated families. All onsets of illness were within seven hours after eating the causative food manufactured on March 22nd. Stool specimens of five patients were found positive for B. typhi-murium. Improper cleansing and protection of equipment, careless working methods in preparing and preserving the custard, and rodent infestation were found in bakery "A." Laboratory investigations indicate that organisms of the coli-aerogenes group are not uncommon in this product, and there were occasional findings of hemolytic and nonhemolytic Staphylococcus aureus. Certain inspection control activities have been developed to determine the cause of these bacterial contaminations and their elimination. It appears practical that a custard product of a *p*H of 4.0 or slightly higher does inhibit bacterial growth in custard or pastry filled with custard. Educational activities relating to handling of all equipment and finished products within the pastry industry, and as to proper storage and preservation by refrigeration in the home, will minimize and eliminate illnesses, such as food poisoning, from these products.

101 Grove Street.

THE PRESENT IMPORTANCE OF TROPICAL DISEASES*

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The subject given me for discussion is the "Present Importance of Tropical Diseases," and since this is a civilian group interested in public health, my interpretation of the subject has been: the importance that tropical diseases may assume to us in California and other Western States under present conditions. "Exotic diseases" seems to me a more appropriate term than tropical diseases since many so-called tropical diseases are already present with us though of minor importance. Most of the important tropical diseases assume their importance only where there are conditions of primitive civilization, including primarily ignorance of hygiene and sanitation. Entirely parallel conditions do not even prevail where the "Grapes of Wrath"[1] was inspired. However, there are a number of important foreign or exotic diseases from which we are free at present; some of these would not require "tropical" conditions to become of importance to us if once introduced.

With the great increase in foreign travel and the increased speed of travel, during the present world upheaval, the chances of introducing exotic diseases is of course greatly increased. Numerous articles have been written on the subject, but most of them have placed emphasis on one or two diseases, and principally from the viewpoint of the Eastern United States. Since I have not yet seen an overall discussion of the problem faced by California and the West, I do not feel that this is a duplication of effort. Moreover, it is my hope that some attention may be focused on definite dangers in regard to certain arthropod-borne diseases not previously pointed out or emphasized. To be inclusive and to comply with time requirements, this of course must be a bare outline.

We face the danger of importation of exotic diseases into California and other Western States by direct routes from both South and West. I shall begin by discussing those from nearest home, from that portion of our own continent to the south of us. Land, sea and air routes connect us. From a recent visit as far as Panama, I found no dearth of American civilian and military travel. Much of the travel is by air. On my return by commercial plane, just before reaching our border the plane was sprayed. The steward apologetically told us before landing that the formality was a required one, gave a little squirt of pyrethrum spray into each upper package compartment, then hastily opened all ventilators to air the plane before we might be annoyed by the odor. I am quite sure it would not have annoyed any mosquito or other arthropod resting below my seat!

DISEASES OF LATIN AMERICA

Classical European or epidemic louse-borne *typhus* begins in Mexico and is found in highland areas in Central and South America. Much of this, until the last year was considered to be endemic typhus which is already present in California and other Western States—endemic in our rat population. Classical typhus, however, is a much more severe epidemic disease. Save where lousiness exists we have little to fear, but during these times of severe crowding, in many defense centers, lousiness is on a definite increase. California has had small outbreaks of louse-borne epidemic typhus in previous years[2] and most certainly can have outbreaks again. Previously it has occurred in association with the importation of Mexican labor.

Filariasis of two types—*Onchocerca volvulus* causing skin nodules and blindness, and *Wuchereria bancrofti* causing elephantiasis—are present in several relatively sharply limited areas. The first is carried by a *Simulium* (buffalo gnat) of which we have many species breeding in our California streams. Fortunately, however, most of these species do not seem to feed on man, so can probably be of but little importance. But, where these breed, could not the known susceptible anthropophilic species, if introduced? Of the vectors of the bancrofti type of filariasis—mosquitoes—more will be said later.

Several diseases carried by *Phlebotomus* flies (sand flies) should be mentioned. *Oroya fever* (verruga peruana or Carrion's disease) occurs only at relatively high elevations and is by no means strictly tropical in distribution. It appears to be spreading in South America or else is being newly recognized in countries other than Peru. Cutaneous and muco-cutaneous *leishmaniasis* (Espundia)—protozoal skin infections—are wide spread in distribution. These are also *Phlebotomus*-borne. *Phlebotomus* flies were unrecognized in California till last fall when two species were found.[3] These adults have been collected in rodent burrows and natural caves for the most part, and refuse to feed on man in the laboratory. But, if these find favorable breeding conditions in California, cannot others when and if introduced?

Much has already been written about the *Triatoma* or cone-nose bug of California and other South Western States, repeatedly demonstrated infected with trypanosomes indistinguishable from those of *Chagas disease* of South America. Human infections, however, have not been definitely recognized.

Yellow fever and *dengue fever* are both present on our continent, dengue fever frequently in Eastern and Southern United States in epidemic form. Cases of dengue fever were present in the San Francisco Bay area last summer, imported from Hawaii, but there were no secondary cases. *Aedes aegypti*, their epidemic vector of the Western hemisphere, however, has not been found in California. It does exist in Lower California and undoubtedly has been introduced repeatedly from there and from plentiful sources in Texas and the Southeast but has never become established here. It would be over optimistic, I believe, however, to predict that it could not become established here! In laboratories, it is one of the most readily reared of all mosquitoes. *Aedes taeniorhynchus,* found in Southern California, will transmit yellow fever in the laboratory, but this observation may or may not have any significance. We are frequently drawing too many epidemiological conclusions from artificial laboratory setups.

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The next disease interests me in particular and has just drawn comment in the "Journal of the American Medical Association."[4] *Venezuelan equine encephalomyelitis,* entirely different immunologically from our Western, Eastern and St. Louis types of encephalitis, has, however, the common factors of causing fatal infections of both horses and man[5] and of being mosquito transmitted.[6] It has been recognized in Venezuela, Colombia and the West Indies, at least. Human laboratory infections have occurred in New York[7] and Brazil.[8] In human cases virus has been readily demonstrated in the blood and in washings from the nose and throat. In our Western equine type, virus is found with difficulty in the blood of the horse and man, and all available data indicate that neither can serve as a source of infection to mosquitoes. Never has this been accomplished experimentally. Mosquitoes, however, can be infected apparently quite easily from the horse in the Venezuelan type infection.[6] We can expect to hear more from this disease! *Mansonia tittilans,* the proven mosquito vector in Trinidad, is one of the most common species of our South East and it extends into Texas.

Leprosy, plague, malaria, hookworm, amebiasis, bacillary dysentery and other so-called tropical diseases we have ever present with us in numerous areas in the West, so I will not discuss any of these except to mention malaria quite briefly a little later.

DISEASES OF THE WEST PACIFIC AREA

From across the Pacific by plane or by boat we have the possibility of having introduced into California and other Western States several of the same diseases and still others.

Most discussed from across the ocean, because we see so many cases among returning military personnel, are *malaria* and *filariasis* (*Wuchereria bancrofti* type). These have been discussed at some length by others.[9-15]

We have no evidence from previous experience that freshly imported strains of *malaria* will behave differently from previously imported strains. More carriers mean more infection, where *Anopheles* vectors are present. Military authorities frankly admit they cannot isolate or restrict movement of all infectious individuals[13-14] so we must increase anopheline mosquito control.

Filariasis, I feel, does not present a problem that need worry us. The number of adult filaria —the only form that produces symptoms— carried by a man never increases beyond that number actually inoculated by mosquitoes. The parasite does not multiply in the mosquito and no mosquito can survive a heavy infection. An infected mosquito probably seldom actually successfully transmits more than one or a very few filaria. Therefore, without repeated infection from many infected mosquitoes, symptoms are unlikely to occur. Probably, only following long continued heavy infection are microfilaria present in the blood. Our military men returning from the South West Pacific are not heavily enough infected to have demonstrable infective stages (microfilaria) in the blood, so mosquitoes here have little chance of becoming infected. Thus, though we have in California species known to serve elsewhere as vectors (*Culex quinquefasciatus* and *Culex pipiens*) we would appear to have no reason to fear. The greatest menace to this country occurred when we imported thousands of heavily infected slaves from Africa. One small endemic center near Charleston, South Carolina, was established. This has practically died out,[15] despite recent quotations from old literature to the contrary.

A rickettsial infection of Australia, the islands of the South West Pacific, the Malay peninsula and the Japanese islands, at least deserves mention. *Tsutsugamushi fever* (Japanese river fever, scrub typhus fever, and also known by other names) is apparently carried by several species of larval *Trombicula* mites. These are quite similar to our red bugs or "chiggers." These larval mites feed once on man or rodents for only a short period of time and then drop off to molt. The nymphal and adult forms are vegetative in habit. There seems to be little chance that a mite in the feeding stage would be imported, but it seems quite possible that one that has molted might be found in a suit case or duffle bag having come from a sock or a trouser leg, or that an adult might have been roled up in a sleeping bag, tent or other piece of equipment spread out in an infected area. Since transovarian transmission regularly occurs, the progeny of such could readily infect rodent reservoirs or man in this country. Who knows if the mite might not become established? Too little is known as yet about these mites to come to any definite decision on this point.

Kala azar or visceral leishmaniasis is, epidemiologically, quite similar to cutaneous leishmaniasis and is *Phlebotomus*-borne. The potential Phlebotomus problem was discussed earlier in connection with Latin American diseases.

Japanese B encephalitis has been responsible for very important epidemics of man in Japan, Formosa, China and Siberia. It has been a plague of major order involving many thousands of persons, and with case fatality rates averaging 40 per cent to 75 per cent. In the first great outbreak of 1924 there were 6,125 cases reported and

3,797 deaths. Its epidemiology is apparently very similar to that of Western equine and St. Louis encephalitis, but with probably a much greater range of reservoir of hosts, including man, horses, and birds since virus can be readily isolated from the blood of all these. One of its principal vectors, *Culex pipiens,* is one of our most common domestic "pest" mosquitoes, the rain barrel mosquito of California. It is also carried by at least one species of *Aedes* mosquitoes. This disease, appears to me to present a graver menace to California and other Western States, where the mosquito-borne encephalitides of a milder nature transmitted by *Culex tarsalis* already flourish so well, than does yellow fever, dengue or filariasis.

Schistosome, or blood fluke infections of man are relatively widespread geographically, with the japonicum type of particular importance in areas across the Pacific. Since man serves as a chronic reservoir of infection, rapid or direct transportation is not an important requisite for the introduction of the parasite. All three forms common to man have been and will probably be brought repeatedly to this country. For their permanent establishment they require the proper type of fresh water snail intermediate host, and raw sewage disposal directly into water. Snails of a number of the same genera and subgenera as those involved elsewhere, are present in California and other Western States. Whether these could serve as hosts is at present unknown. Because of our modern methods of treating sewage in many localities infection rates certainly could not be high, but there is a distinct possibility of certain rural areas becoming foci of infection. Carriers of these parasites cannot be considered harmless until more knowledge is available in regard to the susceptibility of our snails.

Paragonimus (lung fluke) infections have been found in a number of returning military personnel, and morphologically similar parasites have been repeatedly found in some of our crayfish. However, since eating of raw, salted or pickled crayfish is essential to acquiring this infection, we need have no fear of it becoming an important problem.

Clonorchiasis, or liver fluke infection, also need give us little worry. Wayson[16] was unable to infect California snails experimentally and since in addition there is not very much raw fish consumed in this part of the country, there is no real problem.

Last, but not least, I mention *cholera.* This disease has already entered and permeated this country repeatedly, but for the past twenty years or more has been successfully stopped at our ports before entry by the alert activities of the U. S. Public Health Service. Can this good record be maintained under the conditions of military emergency?

CONTROL MEASURES

Now let us review very briefly what is being done to prevent introduction of these exotic disease agents or vectors. Let us consider them in epidemiologic groups.

(1). *Diseases transmitted from man to man:*

Cholera is the only one considered in this group. I can speak with no authority in regard to how well the customary port quarantine functions are handled with routine arrivals of military planes and ships. Of this I am certain, however, that under special emergency conditions planes do not always land where expected.

(2). *Diseases wherein human or other animal reservoirs may infect vectors which are now present:*

Malaria, bancrofti filariasis, Japanese B encephalitis and Venezuelan equine encephalomyelitis come under this classification. *Wuchereria bancrofti,* I believe, needs no further mention. Anopheline control in and about military camps, and about ports and airfields where planes from foreign sources arrive is being carefully carried out by coöperative military and U. S. Public Health Service efforts. Other malaria control measures are carried out by well organized crews with local, State and Social Security funds. In addition, three mobile *Anopheles* control units of the Public Health Service are available to rush into any district in this State where an outbreak might occur. Control would undoubtedly be prompt and effective.

In contrast to *Anopheles; Culex, Aedes* and other genera are permitted in many places to breed unmolested, despite the fact that *Culex*-borne encephalitis in valley areas is already a human disease far more important than malaria is at present in those same areas. In certain areas where efforts were previously made to curtail all mosquito breeding, with the help of Social Security funds, with the onset of war these efforts were stopped by specifying that the funds could be used only for anopheline control. *Culex* and *Aedes* are breeding unmolested in and about some military camps and about numerous seaports and airports. This is an open invitation to Japanese B, Venezuelan and Eastern equine types of encephalitis. Mosquito spraying, required on arriving planes and ships, is sometimes done in a careless manner as I have personally observed and have been told by others. Those doing the work are not always conscious of its importance. Mosquitoes have been found on planes in unsprayed depressions where folding landing gear offers some protection. Occasionally reports are heard to the effect that some of the military planes under special dispensation escape spraying and inspection.

According to Wright,[15] the military authorities have agreed to do something about controlling the movement of *Schistosome* carriers and experimental work at the National Institute of Health is being carried out on snails of the United States.

(3). *Diseases for which the vector must be introduced as well as the etiologic agent:*

Species of *Simulium* capable of transmitting onchocerciasis; *Phlebotomus* capable of transmitting Bartonella of Oroya fever, *Leishmania* of cutaneous, muco-cutaneous and visceral types of leishmaniasis and the virus of papatacci fever (a disease like dengue from the Middle East, not previously mentioned); *Aedes aegypti* of the Eastern hemisphere *Aedes albopictus* vectors of yellow fever and dengue; and *Trombicula* mites of tsutsugamushi fever might be introduced by any of the means mentioned above for mosquitoes. It might be forseen that infected individuals of any of these species could be brought by some unfortunate occurrence to the West Coast of the United States, such as that which brought *Anopheles gambiae* to Brazil and *Aedes aegypti* to the Western Hemisphere and to Hawaii.

To make introduction of these vectors less likely, efforts should be doubled. Control measures against breeding of Culicine mosquitoes, and other arthropods, in addition to anopheline control should be considered for areas about ports and airports, also in and about military reservations, against the possibility that one or more species be introduced. This same control of breeding places would greatly lessen the danger from the introduction of a man or animal serving as a reservoir of infection.

DIAGNOSIS

Finally, let us consider the importance of the diagnosis of exotic diseases in this country and what is being done about it. We will not concern ourselves here with the welfare of the infected individual, but with the public health aspect. Certainly, to prevent spread of many infectious diseases, early recognition by proper diagnosis is of paramount importance.

It so happens that at present, at least, most infected individuals are under the complete control of the Army or the Navy and the obligation of diagnosis rests with them. Some of their medical officers and sanitary officers are trained to cope with the problem and many are not. The University of California has given or participated in formal and informal courses of training and rendered special laboratory aid to many of these men. I presume other medical schools have done likewise. Our new medical school graduates, both civilian and military, are now much better equipped to meet the problem through a greatly increased number of hours of didactic, laboratory and clinical teaching in tropical medicine, with the help of the military hospitals and their medical officers, where case material is available. A few instructors in each medical school have been given the opportunity to receive further special training in tropical medicine at our best schools of tropical medicine and in Central America, through the Association of American Medical Colleges and at the expense of the Markel Foundation. Thus, there are several new Western nuclei of trained men, in addition to those previously present. It would seem wise, therefore, for physicians who are insufficiently trained, to keep their level of suspicion high and to refer suspected cases to these specialists.

To help meet this need a Diagnostic Clinic for Tropical and Exotic Diseases has recently been established at the University of California Medical Center. Patients or properly prepared specimens can be sent there and I would urge that these or other facilities be used. There are also available in our civilian institutions, specialists in the identification of insects and other large parasites and special laboratories for the diagnosis and study of virus and rickettsial diseases, plague and many other of the special problems not handled in most clinical laboratories. California is unusually well equipped for these special problems.

SUMMARY

California and other Western States face a greatly increased hazard of importing certain exotic diseases from Central and South America and from across the Pacific. The possibilities in regard to a number of these are discussed. Venezuelan and particularly Japanese B type of encephalitis are considered to be of particular importance, and a hitherto unrecognized danger, with no planned measures in effect to reduce the danger. Imported malaria is expected to be no different from local malaria, and no serious outbreak should occur with present control measures. Filariasis of the bancrofti type presents no problem. Several Phlebotomus-borne diseases are mentioned, since Phlebotomus flies have, for the first time, been found in California. Onchocerciasis is mentioned because several species of *Simulium* flies are present in California. Absence of *Aedes aegypti* from California and most other Western States and their failure to become established, though present to the immediate south, greatly reduce, for the time being, any danger of yellow fever and dengue, even though patients are introduced. Fluke infections are also discussed but the possibility of any serious problem appears negligible. Some pathogenic flukes have been present for years without spread in man. Methods for prevention or control are recommended for those diseases considered potentially dangerous. Recommendations and suggestions are offered regarding how to obtain proper diagnosis on imported or autochthonous cases.

Third and Parnassus Avenues.

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THE PROBLEM OF SYPHILIS AS HANDLED IN THE U. S. NAVY*

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The Naval Medical Officer functions as physician, guide, and public health officer in his approach to the problem of syphilis. He is expected to dispense information to the men to aid in the prevention of venereal disease. Of course, this is an individual approach depending on the temperament of the medical officer. The realists endeavor to stress the importance of prophylaxis, the early reporting of suspected venereal infection and rigid attention to treatment when once the diagnosis of syphilis has been made. An intensive educational campaign is constantly in effect, attempting by visual education, cartoons, picture strips, movies and talks, to discourage promiscuous sexual exposure. The frequency with which drunkenness and venereal infection are associated is stressed. The men are urged to use condoms or to take immediate and adequate prophylaxis if exposure does occur. Nevertheless, there are many man-days lost in the Navy because of syphilis.

INCIDENCE

In one single naval district the annual venereal disease rate was 25.57 per thousand of personnel, and the syphilis-gonorrhea rate was 1:13. With the possibilities for exposure and the young virile type of man concerned, this does not seem to be an extremely high incidence. It certainly compares favorably with the figures published previously in surveys of the population at large.

Because of the educational program and the frequent medical inspections of the crew, a very high percentage of the cases of syphilis report for treatment early in the course of the disease. Of the 51 new cases which have come under my observation, during the past year, 30 have been seronegative primary, and 21 have been seropositive primary syphilis. Our corpsmen are carefully taught the technique of dark-field examination, and their results are verified by a competent pathologist.

With our ships making port in every part of the world, it is natural that much of our syphilis is contracted in places outside the United States. Such cases seem no different in the response to treatment than our own native brand of syphilis. One interesting pair of syphilitics came back from a port in the Southwest Pacific. Both cases were acquired from the same source. Both were diagnosed in the seropositive primary state. Both received adequate intensive treatment with mapharsen. One of these patients is running the usual course of well-treated syphilis, and the other one developed a typical malignant syphilis which, for six months, has been a difficult problem.

DIAGNOSIS AND TREATMENT

In the approch to diagnosis, it is standard practice to follow up all cases of gonorrhea or chancroid with a Kahn test in two months. Dark-field examinations are done on all penile lesions. Occasionally an innocent-appearing lesion is teeming with Treponema Pallidum.

Treatment is fairly well standardized, using continuous overlapping courses of bismuth and an arsenical. Lapsed treatment is less common than in civilian practice, because of the better control which can be maintained over the patient; and although it is not possible for me to obtain statistics, the impression is quite definite that there is a minimum incidence of late complications.

The screening of syphilitics under treatment to prevent their assignment to duty where adequate treatment is not available, is one of the important duties of a Naval Medical Officer. Obviously it would be difficult for a Marine in a fox-hole, or a sailor on a submarine to receive regular and adequately supervised treatment.

As the syphilologist in a fairly large naval hospital, I am frequently asked to review the physical condition, serology, and spinal fluid findings in men who have previously been treated for syphilis. Regulation provides that such study is necessary before promotion from the enlisted personnel to warrant a commissioned rank. It is very seldom that serologic or physical stigmata of syphilis are found in these examinations. A follow-up study of syphilis in the navy, such as the studies conducted by the Coöperative Clinical Group, would be a protracted and arduous task, but would no doubt yield statistics of extremely great accuracy because of the ability to follow such a high percentage of the cases.

False positive serologic reactions have been a most interesting and important problem during my last year of duty. All such reactions are referred for opinion. Here again, no statistical data were kept, and it would be almost an impossible task to obtain them now. When the Kahn test is positive, another specimen is taken, and the Kahn and Wasserman are both done. The syphilologist then studies the patient for clinical evidence of syphilis. If malaria, catarrhal fever, one of the exanthemata, or vaccination or immunizing injections have recently preceded the appearance of seropositivity, and no history or clinical evidence of disease can be obtained, judgment is withheld, and serology repeated in from two to three weeks. In a very large number of such cases the serology has become negative and remains so. The vast majority of seropositivity without history or physical evidence of disease show such reversal within a few weeks. The Kahn is frequently frankly positive in these cases, with a doubtful or weakly positive Wasserman. There have been a few instances in which reversal did not occur, and spinal fluid studies have revealed asymptomatic neurosyphilis.

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* Read before the Section on Dermatology and Syphilology, at the Seventy-third Annual Session of the California Medical Association, Los Angeles, May 7-8, 1944.

This article has been released for publication by the Division of Publications of the Bureau of Medicine and Surgery of the U. S. Navy. The opinions and views set forth in this article are those of the writer and are not to be considered as reflecting the policies of the Navy Department, or the military service at large.

IN CONCLUSION

In conclusion, it seems safe to state that the boys and young men who constitute our fighting Navy are probably less likely to acquire syphilis than those of the same age in college or industry; and they are more likely to receive prompt diagnosis and treatment which under military control should approach the best obtainable results.

U. S. Naval Hospital.

Battle Against Tropical Diseases

How the battle against disease is being won along with the war against the Axis was the encouraging report recently given by Dr. Wilton L. Halverson in discussing "Men, Malaria and Medicine" at the annual Farraday lecture at Junior College Auditorium, in Pasadena.

His address, given before civic and educational leaders as well as students, proved reassuring in the hope it held for control of malaria, typhus, plague, yellow fever and filariasis.

He said malaria is the greatest cause of disease and death, taking its toll of 7,000,000 a year, with 200,000,000 cases on record at the present time, and that it probably will be the only tropical disease introduced into this country after the war. "But we will be able to cope with it," the speaker declared.

While California has no malaria at present, she does have the mosquito which carries it, he said. He described in detail by means of a chart the habits of the greatest carrier, the Anopheles mosquito.

Typhus fever, transmitted by lice and fleas and now showing in a virulent form in the Mediterranean, is being controlled by a new insecticide and consequently "is not a menace to our armed forces." Yellow fever, transmitted from man to man by mosquitos, is being controlled by vaccination, and filariasis, caused by a worm, should give no trouble in this country, Dr. Halverson said.

Plague has broken out in California at various times since 1900. It started in India and China, and now is present in wild rodents in the 11 western states. It is transmitted by the rat flea to man. There are two kinds, one causing swelling of the glands, the other going into pneumonia, "but plague will not be a real problem to either the armed forces nor to our civilians after the war," Dr. Halverson assured the audience.

Malaria Tests for Overseas Men Urged by Doctors

The blood of all persons returned from regions where malaria is prevalent should be examined for traces of the disease, and all persons registering positive tests should be treated immediately, according to two Army doctors.

Capt. Stanis P. Carney of the Sanitary Corps and Capt. Noah B. Levin of the Medical Corps in a recent article said that many persons returning from malaria regions, without symptoms of the disease, carried organisms which cause malaria in their blood, making them liable to active infection and causing them to become carriers as much as a year after the infection was contracted.

Citing the case records of 2,723 Italian prisoners of war, they pointed out that 9.7 per cent registered a positive blood smear, 2.1 per cent had active malaria, 6.5 per cent had a history of malaria, while 59 per cent who had malaria were newly infected and 83 per cent of those with positive smears had no history of the disease.

Anti-malaria precautions taken by the Army has kept the incidence of infection down among troops, the doctors said, but all men returned from infected regions should be examined to protect them from further attacks and eliminate them as carriers.

Extremists Rebuked

Facile-tongued extremists have long claimed that a popular demand exists for government-dominated medical care. In response to this alleged demand, they have introduced legislation in Congress which would tend to make the Federal Government master of the medical profession and to vest politicians with authority over the health needs of the people.

Advocates of such a set-up were riding high as long as no factual information was forthcoming as to the wishes of the people on this score. But now the situation is changed, as the National Physicians' Committee for the Extension of Medical Service has had a comprehensive survey of opinion made, and the results are such as to serve as a rebuke to those who maintained that a majority of the people wanted politically administered medicine under control of the Federal Government.

According to the survey, the people are strongly in favor of broadening plans for easy individual prepayment of costs of unusual or prolonged illness. They are security conscious. But, they do not want political planning to interfere with personal freedom, which they feel would be the result if the Federal Government set itself up as a pill dispenser. A breakdown of the figures compiled through the survey reveals that only 16 per cent of all the people favor a 6 per cent payroll deduction from wages (as proposed in the Wagner-Murray-Dingell bill) for the Federal Government to provide medical care and hospitalization; only 19 per cent favor medical care for the indigent by the Federal Government. It was indicated that care of the indigent should be the responsibility of the States and local agencies. Only 13 per cent expressed the opinion that compulsory health insurance would provide a satisfactory solution to the problem of payment for medical care costs; and only 24 per cent thought Federal control would be a good thing for the medical profession.—Editorial in San Francisco *Underwriter's Report.*

Gibson's Bandage.—The American gynecologist, William Gibson, was one of the pioneers in Caesarean section. He performed the operation twice upon the same patient successfully. He acquired fame in the war of 1812 by removing a bullet from the leg of General Winfield Scott. It was about this time that he was active in establishing the medical department of the University of Maryland, and became its first professor of surgery.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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E. VINCENT ASKEY, M. D....................Speaker
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JOHN W. CLINE, M. D..Chairman, Executive Committee
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON...................Executive Secretary

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W. C. Cutting, Menlo Park
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OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Twentieth (320th) Meeting of the Council of the California Medical Association

The meeting was called to order in the Green Room of the Hotel Fairmont, in San Francisco, at 10:30 A.M., on Sunday, August 6, 1944.

1. **Roll Call:**

Present: Councilors Philip K. Gilman, Chairman; E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Sidney J. Shipman, Herbert A. Johnston, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary.

Absent: Councilors Lowell S. Goin and Karl L. Schaupp.

Present by Invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman, Committee on Public Policy and Legislation; T. Henshaw Kelly, Secretary, Board of Trustees of C.P.S.; A. E. Larsen, Secretary of C.P.S.; Dwight L. Wilbur, C.M.A. Delegate to A.M.A.; Albert J. Scholl, Chairman, Executive Committee of Editorial Board; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate Legal Counsel; Ben Read, Secretary, California Public Health League; W. Glenn Ebersole; and William P. Butler, Superintendent of the San Jose Hospital.

2. **Minutes:**

Minutes of the following meetings of the Council were submitted and actions taken approved:

(a) Council Meeting (316th) held in Los Angeles on May 6, 1944.

(b) Council Meeting (317th) held in Los Angeles on May 7, 1944.

(c) Council Meeting (318th) held in Los Angeles on May 8, 1944.

(d) Council Meeting (319th) held in Los Angeles on May 8, 1944.

(e) Executive Committee meeting (183rd) held in San Francisco on June 4, 1944.

(Above minutes were printed in CALIFORNIA AND WESTERN MEDICINE for June, 1944, on pages 323-329, inclusive.)

3. **Membership:**

(a) A report of the membership, as of August 5, 1944, was submitted and placed on file. The membership roster showed distribution as follows:

Total members (civilian and military) listed for year 1944: 7,505.

Total members in military service: 2,128.

(b) Upon motion made and seconded, it was voted to reinstate 61 members of year 1943, whose membership, because of nonpayment of dues, had automatically lapsed on April 1, 1944; but whose dues had been paid since the last Council meeting on May 8, 1944.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

(c) Upon motion made and seconded, retired membership was granted to the following member, whose application had been received in accredited form from his county society:

Charles Robert Blake, Contra Costa County.

4. **Financial:**

(a) A cash report, as of August 5, 1944, was submitted.

(b) Report was made concerning income and expenditures for July and for seven months, ended July 31, 1944.

(c) A balance sheet, as of July 31, 1944, was submitted.

Upon motion made and seconded, the above reports were received and placed on file.

(d) Concerning salary arrangements, on motion made and seconded, it was voted that matters pertaining to employment and salary adjustment for Mr. Glenn Ebersolè be referred to the Chairman of the Council and the Executive Committee; and further that the Executive Committee be empowered to handle any just and equitable salary arrangements in connection with the work of Dr. George H. Kress as Secretary and Editor, and that these salary arrangements be made in conformity with changing times and conditions.

5. **Interim Appointments:**

Council Chairman Gilman reported upon tentative appointments made since the last Council meeting held on May 8, 1944.

Upon motion made and seconded, it was voted that the appointments, which follow, be confirmed:

(a) Lloyd E. Kindall to C.M.A. Committee on Public Policy and Legislation, vice Anthony Diepenbrock, resigned.

(b) Mr. Glenn W. Ebersole, now engaged in public relations work for the California Medical Association.

(c) A Special C.M.A. Committee, appointed for conference with Dr. Lester I. Newman of the State Fund, re: Industrial Accident Fee Table. The committee appointed consisted of Doctors Nelson J. Howard, Frederic C. Bost, Hartley F. Peart, Esq., and Doctor Philip K. Gilman, ex-officio.

(d) Dr. Beth Pinkston, Los Angeles, appointed Secretary of Section on Radiology, vice Dr. J. B. Irwin, San Diego (a nonmember) elected at the Annual Session by the Section through error.

(e) Dr. Eaton M. Mackay, member of San Diego County Medical Society, and staff member of Scripps Metabolic Clinic, to be nominated to Governor Earl Warren for membership on Nutrition Committee of the California State War Council.

6. **"Liaison Committee of Six" on Medical and Hospitalization Service Plans in California:**

For the Liaison Committee of Six, consisting of three members of the California Medical Association and three members of the Association of California Hospitals, which held a conference meeting in the C.M.A. offices on June 18, 1944 (as per minutes which appeared in California and Western Medicine, for June, on pages 27-30), Dr. John W. Cline, chairman of the C.M.A. group, made further report.

Dr. Cline read a letter, having date of July 17, 1944, addressed to him by Mr. Jesse V. Buck of the Murphy Memorial Hospital, Whittier, California, who is chairman of the Committee of Three representing the Association of California Hospitals. Dr. Cline also read his reply to Mr. Buck, having date of August 4, 1944. Copies of these letters are appended to these minutes. It was agreed that copies should also be sent to the members of the C.M.A. Council.

Special comment concerned itself with future plans regarding medical and hospitalization service. Upon motion made and seconded, it was voted that Dr. Cline's suggestion that he call another meeting of the Committee of Six, at such time as may be deemed best, be approved.

Concerning Dr. T. Henshaw Kelly's membership on the C.M.A. Committee of Three, inasmuch as he was also the representative of California Physicians' Service, it was agreed that this matter should be referred to the Chairman of the Council, Dr. Gilman, for such action as may be deemed best. (Dr. R. Stanley Kneeshaw was appointed.)

7. **California Physicians' Service:**

Dr. T. Henshaw Kelly, Secretary of the Board of Trustees of C.P.S., was called on to report concerning the present status of this statewide medical service plan, for which organization the House of Delegates of the California Medical Association now constitutes the majority of the Administrative Members.

Dr. Kelly spoke of the new arrangements made for the southern section of California, and stated that the work under Mr. Bowman was proceeding in satisfactory manner.

Monthly income of C.P.S. was now about $125,000.00, and some 8,000 new beneficiary members were being added to the roster each month. In the northern section of California, some 21,300 hospital service contracts were outstanding. The gross business of C.P.S. during the last fiscal year amounted to a total of $1,340,315.

Reference was made to a plan whereby statements submitted by physicians for professional services rendered would be paid with greater promptness. This is now possible because the unit value is worked out a month or so in advance, and since past experience shows that no mishap can accrue therefrom under ordinary circumstances, the bills will be paid as they are received and approved, thus permitting the financial activities to be carried over throughout each month, instead of massing the same for action within a few days.

Mention was made of local advisory groups that have been appointed, and the listing of the names of professional members on the reverse side of local territory letterheads. Local suboffices were being established in cities such as Long Beach.

Efforts were being made to secure a high-grade business executive administrator for California Physicians' Service, as authorized by the C.M.A. Executive Committee at its meeting held on June 4, 1944. Because of the importance of the position, it was felt that the right man should be secured.

The problems which had arisen in connection with hospitalization services in several portions of the State were discussed in detail.

Concerning the special problem in the Richmond-San Francisco Bay area, report was made on the costs thereof to date. It was pointed out that the California Medical Association went into this project upon the request of the Procurement and Assignment Coördinating Committee, and after consultation with the physicians of the area. It was felt that efforts should be made to have better coöperation by the Richmond physicians. It was voted that the attention of the Coördinating Committee of Procurement and Assignment be called to the present situation at the next meeting of that body.

Legal Counsel Peart reported that no answer had as yet been received to his communication to the Legal Counsel for the Association of California Hospitals with respect to the situation in Alameda County. Legal Counsel briefly reported that in Alameda County several hospitals accept Hospital Service of California cards and patients and extend credit for hospital bills to H.S.C., but that the same hospitals refused to recognize or accept C.P.S. cards and require C.P.S. patients holding such cards to pay their bills in cash and sometimes in advance. It was stated that there was apparently no financial reason for this attitude, as C.P.S. has offered to deposit the sum of $1,000.00 with each of these hospitals as a revolving fund, and to replenish the fund as expenditures were made from it. It was stated the hospitals rejected this offer on the ground that they desired only to deal with H.S.C. and no other organization.

Dr. Gilman reported that he had written to Dr. Lum, President of the Alameda County Medical Association, and that Dr. Lum had replied that the situation would be brought to the attention of the Alameda County Medical Association as soon as the vacation period is over.

It was moved, seconded, and unanimously carried that Dr. Kindall, Councilor from Alameda County, be requested to take up the matter with the Alameda County Medical Association and the hospitals concerned at the earliest possible date, and endeavor to convince the hospitals of the desirability of treating California Physicians' Service on an equal basis with Hospital Service of California and thus avoid the necessity of further action.

8. Maternity-Pediatric Program of Federal Children's Bureau:

In the absence of the chairman of the Special C.M.A. Committee on Maternity-Pediatric Work, Dr. Karl L. Schaupp, report was made by Secretary George H. Kress.

Reference was made to Washington, D. C., conferences of Dr. William Benbow Thompson of Los Angeles, who represented the special C.M.A. committee, and of Dr. Jessie Bierman, Chief of the Bureau of Maternal and Child Welfare of the California State Board of Public Health, who had attended a more recent conference with Federal Children's Bureau Officials in Washington, D. C.

The increased responsibilities of physicians, through faulty phraseology in the "Form M" contract of E.M.I.C., were discussed. The suggestions concerning consultants, supplementary fees, and other items as brought out in the reports by Dr. Thompson, also received consideration. (See CALIFORNIA AND WESTERN MEDICINE, for August, on page 72.)

It was agreed that it might be wise to postpone action other than that previously taken, until more was learned concerning the decisions of the Federal Children's Bureau on the suggestions that had been submitted by Drs. Thompson and Bierman.

Upon motion made and seconded, it was voted that the Special C.M.A. Committee on Maternity-Pediatric Work be authorized to communicate with component county societies, and to urge each county society to appoint a Special Maternity-Pediatric Committee that could work with and through the C.M.A. Committee on Maternity-Pediatric Work in order to promote objectives best suited for local and other needs, and in line with plans approved by the C.M.A. Committee and Council.

9. California and Western Medicine:

Dr. Albert J. Scholl, Chairman of the Executive Committee of the Editorial Board, submitted for the Executive Committee of that Board, a letter dated August 5th, in which recommendations were made concerning four symposia on wartime problems in medicine, the same to be printed, if possible, in the issues of October, November, December, and January next. To do this, it will be necessary to use an eight instead of a ten point type, and it will also be incumbent upon contributors to the four symposia, to decrease the length of their papers to permit each symposium to remain within the space available. Dr. Scholl stated that it was planned to have the Secretary-Editor inform the contributors to the four symposia concerning the details of procedure.

The recommendations concerning these four symposia were accepted.

Concerning the recommendation of the Executive Committee of the Editorial Board that at least one-half of each issue should be allocated to text pages, it was agreed that it might not be possible to do this every month, but in any event, the effort should be made to permit the text portion of CALIFORNIA AND WESTERN MEDICINE at the end of each year to have had at least one-half of the available space, the remaining portion to be made available for commercial advertisements and announcements. The attainment of this end to be through mutual arrangement between the Editor and Business Manager of CALIFORNIA AND WESTERN MEDICINE.

Dr. Scholl read from the minutes of the meeting of the Executive Committee of the Editorial Board, held on August 5, 1944, in relation to the above, and called attention likewise to need for additional room space, if the editorial work of CALIFORNIA AND WESTERN MEDICINE was to be efficiently carried on. Under the existing crowded conditions, it is impossible to find space for adequate filing and cross filing of manuscripts, galleys and other material. It was agreed that authority be given to the Executive Secretary to acquire such additional space as soon as opportunity presents.

For the Executive Committee of the Editorial Board, Dr. Scholl also called attention to the need for additional clerical assistance if the work of CALIFORNIA AND WESTERN MEDICINE is to be properly carried on; and the suggestion was made that at least a half-time clerical assistant should be added to the staff.

Council Chairman Gilman stated that the facts brought out by Dr. Scholl had also come to his attention and he felt that steps should be taken to bring about a betterment of conditions.

10. Industrial Accident Fee Table:

Mr. Peart stated that, at the time of making the surcharge order increasing the fees 15 per cent for the Duration, the Industrial Accident Commission had appointed a study committee consisting of representatives of the following: California Inspection Rating Bureau, State Compensation Insurance Fund, California Self-Insurer's Association, the Industrial Accident Commission, the Mutual Reciprocal Insurers, the Nonparticipating and Participating Stock Insurers, the State Insurance Commissioner, and the California Medical Association.

Legal Counsel Peart stated that the Subcommittee of the Assembly Interim Committee on Governmental Efficiency and Economy, consisting of Assemblymen King, Waters, and Watson, appointed to investigate the Industrial Accident Commission, had held one hearing at the State Building in San Francisco; that at this hearing, Chairman Scharrenberg and other representatives of the Commission had testified of the organization and operations of the Commission; that further hearings were scheduled at San Francisco August 17 to 19. Thereafter, the Subcommittee had indicated that it had desired to hear from representatives of the California Medical Association. Legal Counsel reviewed some amendments to the act which had been indicated by the fee schedule proceedings, which suggestions he said the special committee proposed to submit to the Subinterim Committee of the Assembly. It was the sense of the Council that the suggested amendments be approved.

Mr. Hunton supplemented the report of the Legal Counsel.

11. **Legal Department:**

Concerning the proposed use of nonmember referees to preside in hearings before the State Board of Medical Examiners, Mr. Peart stated that the Committee of the Judicial Council of the State Bar, having charge of this subject, was still meeting on the matter and had not rendered its final report. He had talked several times to Judge Nourse, the Chairman of the Committee, and Judge Nourse advised that final report could be expected about September 15th. (See CALIFORNIA AND WESTERN MEDICINE, August, 1944, p. 126.)

12. **C.M.A. Delegates to House of Delegates of A.M.A.:**

Dr. Dwight H. Murray made a report concerning the meeting of the House of Delegates of the American Medical Association, the same being appended to these minutes.

The action of the A.M.A. House of Delegates concerning the resolutions submitted by the California Medical Association was referred to. (See CALIFORNIA AND WESTERN MEDICINE for July, pages 5 and 6.)

Letters from Delegates William R. Molony, Sr., and Robert A. Peers were also read.

Special reference was made to the offices which are now in operation in Washington, D. C., (under the A.M.A. Council on Medical Service and Public Relations, and of the United Public Health League).

13. **Committee on Public Policy and Legislation:**

(a) Dr. Dwight H. Murray, Chairman of the C.M.A. Committee on Public Policy and Legislation, reported that a meeting was held with allied groups—hospitals, pharmacists, dispensing opticians and dentists—on Saturday, August 5, 1944, for discussion of state and national legislative candidates. . . .

(b) Concerning the United Public Health League, Dr. Murray stated a meeting of the California Council of the League was held Saturday, August 5, 1944, for discussion of the League's progress and activities. It was agreed that: (a) the League should expand its service in Washington through procurement of larger quarters and additional office help, and through establishment of a reference library on medical legislation, prepayment plans sponsored by medical groups, etc.; (b) the League should engage in greater publicity as a means of attracting members from other States; and (c) California physicians should be better informed on the League. In connection with the last named item, Doctor Murray requested the Council to authorize the utilization of United Public Health League material by Mr. Ebersole, in his tour of the county medical societies, and it was so agreed.

(c) Mr. Ben Read, Secretary of the California Public Health League, was called on to give further information concerning the activities of the Washington, D. C., office of the United Public Health League, and the contacts that had been thus far made.

(d) After discussion of the subject, it was voted that Proposition No. 4 on the California ballot in re: exemption of hospitals from taxation, be approved.

(e) A letter of July 14, 1944, from Ernest G. Sloman of San Francisco in re: a bill introduced by Mr. Rivers to provide more efficient dental care for the personnel of the United States Navy, was called to the attention of the Council, and on motion made and seconded, it was voted to approve the said H.R. 4216.

14. **Proposed Amendment to C.M.A. Constitution:**

A letter dated June 6, 1944, received from Dr. Robert A. Peers of Colfax, relative to limited tenure of office for Delegates and Councilors, was read.

After discussion, it was agreed that the Council Secretary should inform Dr. Peers that it is the privilege of any member of the California Medical Association to submit to the C.M.A. House of Delegates, through a member thereof, amendments to the Constitution and By-laws.

15. **Time and Place of Next Council Meeting:**

Upon motion duly made and seconded, it was voted that the time and place of the next Council meeting should be left to the decision of the Chairman.

16. **Adjournment:**

After informal discussion of several informative items, motion was made and carried that the meeting adjourn.

PHILIP K. GILMAN, *Council Chairman.*
GEORGE H. KRESS, *Council Secretary.*

EXECUTIVE COMMITTEE OF CALIFORNIA MEDICAL ASSOCIATION

Minutes of the One Hundred Eighty-fourth (184th) Meeting of the Executive Committee of the California Medical Association

An informal meeting of members of the C.M.A. Executive Committee, resident in San Francisco, was held in San Francisco, on Friday, August 25th, at the noon hour.

By mail vote, the minutes which follow, and the actions taken, were approved by all members of the Executive Committee.

1. **Roll Call:**

Members Present: John W. Cline, Executive Committee Chairman; Philip K. Gilman, President-Elect; Karl L. Schaupp, Past President; and George H. Kress, Secretary-Editor.

Present by Invitation: John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel, and Howard Hassard, Associate Legal Counsel.

Absent: Lowell S. Goin, President, and E. Vincent Askey, Speaker.

2. **Minutes:**

This being an informal conference, and the minutes of the 183rd meeting having been ratified at the meeting of the C.M.A. Council held on August 6, 1944, no further action was taken thereon.

3. **Appointment of Glenn W. Ebersole:**

Item 4 (d) of the minutes of the 320th meeting of the Council held on August 6, 1944, referring to employment of Mr. Glenn Ebersole, was presented by Council Chairman Gilman. After discussion concerning the duties of Mr. Ebersole, it was agreed that the general relationship at present obtaining should continue, with the provision that Mr. Ebersole would have as his chief to whom to turn for instructions, Council Chairman Gilman or Doctor Gilman's representative. It was agreed that in the matter of salary, Doctor Gilman should proceed in line with the general discussion as brought out in the meeting.

4. **Secretary-Editor Salary Adjustment:**

In the absence of Doctor Kress and Mr. Hunton, the salary of Doctor Kress was considered, and the permissible increase of 15 per cent was granted, the same becoming operative on August 1, 1944.

Additional clerical aid for CALIFORNIA AND WESTERN MEDICINE was referred to Dr. Gilman for adjustment.

5. **Vacancy on Liaison Committee of Six:**

Doctor T. Henshaw Kelly having resigned as a member of the Liaison Committee of Six (as one of the three members representing the California Medical Association), it was agreed that Council Chairman Gilman should appoint Doctor R. Stanley Kneeshaw of San Jose to fill the vacancy.

6. **Committee on Medical Defense:**

An appointment, as regards a vacancy on the Committee on Medical Defense, due to resignation of R. Stanley Kneeshaw, was referred to Council Chairman Gilman, with power to act. (Council Chairman Gilman has appointed C. Kelly Canelo, to fill the vacancy.)

7. **Medical Service in the Richmond-San Francisco Bay Area:**

A progress report concerning the medical service rendered in the Richmond (San Francisco Bay Region) housing area was made, it being stated that it might be possible for the activity to meet its expenses during the current month (of August).

The various phases of the medical service problem which had arisen in this crowded war industry area received comment; and the importance of maintaining this activity for the time being was brought out. It was agreed that, with certain limitations, the existing procedure should continue. (See also C.M.A. Council minutes of the 320th meeting on August 6, 1944, under Item 7, September California and Western Medicine, page 152.

8. **"Liaison Committee of Six": On Medical and Hospitalization Service Plans in California:**

Chairman Cline of the C.M.A. Committee of Three on the Committee of Six made further report concerning communications that had passed between himself and Mr. Jesse V. Buck, Chairman of the Association of California Hospitals' Committee of Three. Doctor Cline referred to his conferences with Doctor H. Gordon MacLean of the Hospital Service of California, relative to merger of hospitalization groups in Northern California, and to problems that had arisen concerning admission of C.P.S. patients to hospitals in Alameda County.

After further discussion of the above items, and existing Blue Cross set-ups, it was agreed that the Committee of Six should endeavor to hold a meeting on Saturday, September 30th, since the Council of the California Medical Association will hold a meeting on Sunday, October 1st.

9. **E.M.I.C. Program:**

Doctor Schaupp, Chairman of the C.M.A. Committee on Maternity-Infant Care made report on the actions taken by the Federal Children's Bureau concerning recommendations submitted by the California Committee. A copy of the digest of actions taken by the Federal Children's Bureau appears in California and Western Medicine, for September, on page 160. Editorial Comment, p. 129.

10. **Rehabilitation Procedures:**

Doctor Cline referred to the hospitalization activities as outlined in the proposed letter to be sent to Mr. H. D. Hicker of the State Bureau of Vocational Rehabilitation.

11. **Repayment of C.M.A.'s Loan to C.P.S.:**

A check for $35,000.00 was received from California Physicians' Service, to pay the amount still due on the loan of $42,000.00 originally authorized at the time the California Medical Association aided California Physicians' Service in its initial organizaton plans. Correspondence and other information relating thereto appears in the California and Western Medicine for September, on pages 169-171.

It was agreed that this check should be deposited in a special bank account, and that report thereon should be made at the next meeting of the Council.

John W. Cline, M.D., *Chairman.*
George H. Kress, M.D., *Secretary.*

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Excerpts from Letters Received from the Late Lt. Colonel George K. Rhodes (MC)

In California and Western Medicine for August on page 112, appeared copy of a news dispatch of August 2nd concerning the sudden death of Colonel George K. Rhodes of the University of California Base Hospital 30. In the June issue of California and Western Medicine appeared one of his letters, dated February 28, 1944.

Below are given excerpts from letters which Doctor Rhodes wrote to personal friends.*

Members of the California Medical Association will find these letters of interest.

* * *

May 1, 1944.

Dear ——————:

I have left the 30th and am now consulting surgeon to 60 odd General and Station hospitals, etc., in this, the busiest and hottest spot on this Island.

About two weeks ago I was called down to General Headquarters in London and after the usual flattering remarks, was offered and persuaded to take the job. It is quite a big job, but probably the most interesting one I could have obtained. I'm traveling five days a week checking up on surgical staffs of all the outfits over here and those arriving. If outfits are weak in spots I replace the officer with one more capable, etc. My life and world have changed overnight for I, for the first time, feel that my 30 years' of experiences are being utilized! It is also interesting to be in on secret conferences and see how extensive the plans and preparations must be to insure the successful invasion of Europe, and the proper care of our sick and wounded.

The new job has boosted my morale a lot, and having a car and driver, I am seeing all this section which is probably the most picturesque and beautiful. The climate here is so much better than that of the Midlands. I've seen more glorious sunshine in two weeks than I did in two years at 30th. Spring and blossoms, thatched houses, beaches, etc., all look like the old oil paintings one associates with England. The only thing that mars the beauty is the war machine, chiefly U.S.A., which covers the country. At the 30th one never knew there was a war on—here you can't think or see anything else—alerts every night, etc. I'm working seven days a week as everyone is here—no time off; hope I can take it!

Brodie Stephens is taking over my job now. Several have been taken out or will be to bolster weaker units. I am very proud of the record the 30th has made, as General Kirk and all inspectors have placed it at the top of the list, both professionally and administratively.

We are hoping and praying that the Jerries get their ears pinned back this summer, for two years plus, over here, is just that much too much!

Glad that you thought parts of my former letter were worth mimeographing and sending to some of our friends. You will be *hearing more interesting news from the 30th soon. . . .*

Best regards to the folks at home. Cheerio.

George K. Rhodes, Lt. Col.
0-238610.

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* For obituary in current issue, see page 169.

Hdq. So. Base Section
APO 519
New York City, N. Y.
July 20, 1944.

Dear Ned:

I have been too busy lately to answer your good letter of June 22, but got off a "V" letter to let you know my intentions were good.

Yes, Ned, I suppose Soto Hall did get a poor view of life in U.S.A., but we all know U.S.A., with all its faults and blunders manages to muddle through as do the British. When the history of this war is written no doubt the errors and extravagance of our leaders will be appalling—but then again the over-all accomplishments are phenomenal. Where the 30th was stationed, one hardly knew there was a war on. The past three months I've been here, I marvel at what you folks at home have done, whatever it cost, to produce the war machinery and organize the armed forces that I'm living with day and night. Since "D" day and before, these old English highways have been packed with convoys and such equipment!! God help those Jerries when the *real* push gets "cracking."

All the people that go home like Soto Hall—Bernbaum, etc., immediately realize the profound difference in the way of life among the folks at home and the natives here in England. But as you say, food and luxuries are scarce over here and we are forced to realize at every turn that the Jerries and the war are at very close range, etc.

Since those "Buzz bombs" have been making daily and nightly visits to England and "London area," I've had a considerable personal experience with them and they are damned annoying to say the least. Fortunately so far the Doodle bugs and I have not met at the same time at the same place! I've been in London with a couple of the minor "blitzs" and somehow I didn't mind them near as much as these which are *not so devastating* as those high explosive bombs! They cause injuries by blast effect chiefly.

The psychological effect is curiously different. You see or hear them coming and the nearest I can describe the subconscious feeling, it is as though some darned fireworks—pin wheel or stray skyrocket had got off the beam and was headed for *you personally!!* You don't have all the flares, ack-ack, tracer bullets and sense of allied fighter planes chasing another human being in a plane, etc. This is particularly true in London area, where I go for a meeting with General Hawley once a month at least.

I have been very busy trying to keep in some sort of contact with about 100 outfits old and new, going and coming—all with their professional and personal problems. Most of these new G.H.'s coming over have been stripped of their chiefs of service and I have to extract specialists, etc., for the older units, and give them in replacement a lot of these 9 month interns who fill up the new outfits. We are giving some of the Battalion surgeons a break too, and substituting them with these 9 month interns, and putting these older and more experienced men in the G.H.'s.

That is the way I rescued ————, who was in such a G.H. and I got him out before he was ordered to some less desirable spot. I got him with the 2nd G.H. (P. & S.—Columbia) affiliated unit which, like the 30th, is going to travel *someday*. There are some fine men in the outfit and I hope he appreciates the opportunity and makes the best of it. It should be like a P.G. course for him. He seemed like a nice chap—only saw him once over here.

We have been trying to evaluate our experiences since "D" Day with the many thousands of cases passing through from the "Far shore."

1. Have seen no cases of tetanus yet in U.S.A. soldiers who got booster doses of toxoid. Have seen several deaths in German P.O.W.—who had not had A.T.S. in early stages. They all get A.T.S. now.

2. Remarkably small number of gas gangrene cases to date and *very* few deaths. Have personally seen quite a few. It is the same old story—clostridium, cellulitis vs. myositis, the former cured by incision and drainage. The later excision of involved muscle groups or amputation if all groups are *definitely* involved. Certainly convinced that sulpho drugs, penicillin, etc., are the answers—not against clostridium infection itself, perhaps, but the contaminants which give symbolic media and aggravate the pathology. A considerable number I have seen *cured* by excision of involved muscle group and not amputation. Serum also used. . . .

3. Chest cases (lots of them) have done very well by aspiration when respiratory difficulty occurs, and putting in 30,000 units of penicillin into chest prophylactically. Remarkably few empyema have developed. If lung remains collapsed and diaphragm fixed, etc., after 12-14 days, chest should be opened and dense coagulum peeled off lung and diaphragm, etc.

4. Lots of diaphragmatic hernias, vascular accidents, arteriovenus anuerisms, etc. Lots of cord and head cases, etc.

All in all a grand job has been and is being done on both sides of the Channel. Air transport brings cases to surgery in the "U.K." within a few hours after injury. I can't say more but you probably read about these things in the home papers—Time, etc.

Yesterday was a little different than usual—started off by donating my pint of blood and then spent the P.M. with Gen. Kirk. He seemed very glad to see me and said he had even mentioned me to Surgeon of 1st Army, etc. He was glad I was on present job. He was with other Generals and Colonels, etc., so I didn't have a great deal of time with him personally. We looked over quite a few patients and discussed various experiences—past and future. Was glad to have had this chance to meet him. My C.O. was with me (i.e., Base Surgeon). It certainly can't do *me* any harm for the S.G. was most cordial and pleased to see me, etc. He certainly is a good man for the job at this time for he is interested primarily in the welfare of the patients and not how many cigarette butts might be under the ash bin, etc., etc. 'Nuf sed!

Will probably get over to France soon on an inspection trip but my Headquarters will probably be here until General Hawley and ———— move over to Paris, etc.

Saw the gang from 30th. Will see them again in *France*. Am enjoying the work even if it is rather long hours and 7 days a week. No more parties and no more Scotch, etc. since I left Carson family and friends thereabouts. They either write or phone once a week, so I get the news and feel like I have some very good friends over here when my morale gets low.

All the best, Ned, to "our Gang" and friends.

Cheerio Pal,

(Signed) GEORGE.

Run into old acquaintances and students all the time. Col. Forgairity, x-ray man at St. Francis, is C.O. of 159 G.H. Hill of Lakeport is in it. Also took Vincent O'Connor out of a F.H. and put him in 159. Lt. Col. Holder, surgeon of San Diego, was C.O. of F.H., and I put him in a Chief Surg. Service of a G.H.

A Lt. Col. Robinson of Oakland is C.O. of another new outfit here. Also saw Dr. Gaspi of San Francisco in one of these spots.

So it goes.

Will be glad to get this show over and get home.

What do you think, Xmas, 1944? or 45??

G. K.

* * *

The work of the late Lt. Col. George K. Rhodes,* in building up the University of California Hospital Unit to a high state of efficiency, is revealed in the following letter to Dr. Howard C. Naffziger from Surgeon General Norman T. Kirk.

* * *

(COPY)

In Reply Refer to SPMC DR 330.13-1

WAR DEPARTMENT
Army Service Forces
Office of the Surgeon General
Washington

April 4, 1944.

My dear Dr. Naffziger:

I have just returned from a trip to Europe where I spent more than two weeks looking over our hospital facilities there under General Hawley. Among the units visited was the hospital operated by the University of California Affiliated Unit and I feel I must write and tell you what a wonderful job these men are doing. It is a bang-up outfit doing a swell job. I don't believe any patient in any hospital is getting better care than those in that hospital. Unfortunately, I didn't see Rhodes. He was away on leave that day. We had a nice visit with the rest of the Staff and spent the night there. The University should be proud of what this Unit is doing now and of what I am sure it will do after D-day.

With kindest personal regards.

Sincerely yours,
(Signed) NORMAN T. KIRK,
Major General, U. S. Army, the Surgeon General.

Los Angeles Member (Captain Ralph Schroeder) Writes on Burma Experiences

From far off Burma comes a letter from Captain Ralph L. Schroeder, a member of the Los Angeles County Medical Association, graduate of the University of Nebraska College of Medicine in 1929. Doctor Schroeder's letter gives an interesting picture of some overseas experiences.

* * *

Dear Doctor ————:

Many thanks for a most welcome letter and class directory. Had the mail arrived as usual it would have reached here Easter week. As it is, it was only ten days behind schedule. Where I am now, mail is as unpredictable as the second front.

With the patter of rain on the roof of the tent and the screeching of cicades outside the door I'll attempt to abide by the censorship rules and give you a word picture of Burma,—or our corner of it.

For many months our hospital was located in India, in reasonable close proximity to native bazaars where we could go for local color, a few trinkets and necessities, and a forceful reminder of how dirty some peoples can live. Prices were always exhorbitant and goods of any kind were always purchased in the Oriental manner of bargaining—75 cents for a can of shoe polish, a dollar for a bottle of ink, $1.50 for four ounces of nails and so on.

Not long after we were established, Chinese merchants arrived to take advantage of the market, but they did bring one welcome thing—the inevitable restaurant. Here we could get a temporary respite from G. I. food for two to five dollars. The food was clean, under close surveillance by Army inspectors and the change was worth it. By contributing more, and arranging for a party of several we could occasionally get a real Mandarin dinner—no questions asked as to contents.

Fresh meat has been, and remains, out for us here. Indian law forbids killing of cows with calf—they all are—or bulls under 10 years of age. Not enough for a good hamburger. Refrigerated meats never get this far—no ice.

We used to get chickens occasionally, but since no care in raising them has ever been exercised, they are always tough, with little breast meat. Then, too, we found that if we didn't kill and eat them right on arrival there wouldn't be enough to go around—too many would die. We tried fattening some geese, but the jackals ran or frightened all the fat off.

Since moving into Burma most of those little things have ceased to bother,—they don't exist here. Here are big, tall stately trees and tangled underbrush. Tarzan variety vines help make up the lattice work. The hills are unbelievably steep, and footing is never too sure. Monkeys and squirrels have the time of their lives in the branches. On every tree, almost, are orchid plants. We've been expecting them to bloom for a month now, but they are demure.

When one adds to this tropical heat and rain the high humidity, the picture is more complete except for snakes and insects by the trillions—pesky flies in all sizes and murderous, vengeful mosquitoes day and night. Considering all these and the fact that an army cannot live off this kind of land—the retreat of Stillwell and his and other parties assume a new importance.

Many of our patients are Chinese. On the whole we are getting to understand them better. But these are Chinese soldiers, in a foreign land—not Chinese in China. That's a page in another chapter. When we realize that wounded Chinese could be American boys our task is easier, and we have pretty well gotten over the feeling that we were Franklin's gift to Madame Chiang Kai Shek. . . .

It's "on with the war here, with a prayer for rapid peace and a lasting one."

Legion of Merit Award to Major Samuel Gendel

For exceptionally meritorious conduct in the performance of outstanding service while operating a hospital in the South Pacific area, Major Samuel Gendel, graduate of the University of California Medical School, Class of 1935, has been awarded the Legion of Merit by the Commanding General of United States Forces in the South Pacific.

Presentation of the Legion of Merit Medal was made April 27, 1944, by Col. A. B. Jones, commanding officer of Torney General Hospital, Palm Springs, California, where Major Gendel is now chief of the General Surgery Section.

In 1942 Major Gendel established a Field Hospital on a South Pacific Island with only partially trained personnel to erect buildings, install equipment and act as nurses and technicians. He served with conspicuous success for 15 months at this post where his initiative, energy, sound judgment and personal example inspired not only the hospital personnel, but contributed to the morale of the entire force. He gave freely of his time in treating the sick among the native population thereby cultivating friendly relationships which were of great benefit to the force which he served.

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* For obituary of late Lt. Col. George K. Rhodes, see in this issue, on page 167.

Major Gendel, a member of the Los Angeles County Medical Association, interned at the Cedars of Lebanon Hospital, Los Angeles, California, where he was surgical resident from 1936 to 1938. He was formerly resident in Surgical Research at Harvard Medical School and before reporting for active duty with the Army in 1940 practiced general surgery in Los Angeles.

Hospital Ship (U.S.S. Hope) Commissioned at Los Angeles Harbor

Nearly ready to perform her mission of mercy in theaters of war, the U.S.S. Hope, third and last of a series of Navy hospital ships built and outfitted at Los Angeles Harbor, was recently commissioned at the United States Naval Drydocks, Terminal Island by Capt. Schuyler F. Heim, U.S.N., commander of the Naval Operating Base.

The entire ship's crew and medical complement gathered on the quarterdeck for the colorful Navy ceremony. Comdr. Albert E. Richards, U.S.N., captain of the U.S.S. Hope, read his orders and posted the first watch after ordering the Geneva Red Cross flag hoisted.

The U.S.S. Hope, a Navy vessel, will be operated under Navy orders by a Navy crew, but like her two sister ships, the U.S.S. Comfort and the U.S.S. Mercy, will carry a full complement of United States Army medical officers, nurses and corpsmen to man hospital facilities.

Among speakers at the commissioning ceremony yesterday were Capt. Fred M. Earle, commanding officer of the Naval Drydocks; Col. James K. Herbert, commanding officer of the Los Angeles Port of Embarkation, and Miss Martha Louise Floyd, director of nursing service of the Los Angeles Chapter, American Red Cross.—Los Angeles *Times*.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association. Military colleagues are invited to use the facilities of these medical libraries.

The addresses of the three libraries follow:

University of California Medical Library, The Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

Feel free to send your medical journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

In a war that stretches out as this one seems to be doing, the side which can manage its resources of men and materials most economically is the side that can best withstand the drain of a long war and is the side that in the end will win.—Peter Edson.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Pay Patient Plan of Los Angeles County General Hospital

California and Western Medicine for July, 1944, on page 34, carried an article giving informative data concerning the scope and work of the Los Angeles County Hospital. Below will be found an article which appeared in *The Bulletin* of the Los Angeles County Medical Association of August 3, 1944, the same being editorial comment on the plan to relieve the shortage of beds in private and semi-private hospitals by making it possible for non-indigent citizens of Los Angeles County to receive medical and hospitalization service in the Los Angeles County Hospital.

In California the county hospitals came into being to primarily care for indigent citizens and emergency hospital work. In the plan outlined below it will be noted that a procedure has been planned through which pay patients will be admitted.

* * *

The Los Angeles County Hospital and the Lanham Act

The dislocation of population occurring because of wartime demands for labor has caused a great shortage of hospital beds in certain areas of the nation. Since Los Angeles is in this category, the Federal government, early in 1943, made funds available to the Los Angeles County General Hospital to equip and maintain seven hundred beds to care for patients financially able to pay for their medical care, but unable to obtain it as a result of crowded conditions in private hospitals.

Our county hospital has always adhered to the policy of admitting only indigent patients except in emergency. The prospect of admitting patients fully able to pay for care immediately created administrative problems within the institution, particularly with reference to the attending staff. It seemed undesirable to permit physicians who were not members of the staff and who were unfamiliar with routine procedure in the hospital, to attend patients. Members of the staff of the county hospital have never accepted compensation for their services, and have never been in favor of making any change in this rule. At the same time it was obviously unfair to expect these physicians to extend their services gratuitously to patients who were able to pay for their medical and surgical care, and who would have been willing to do so had private accommodations been available.

Accordingly a special committee under the chairmanship of Mr. A. B. Ruddock, member of the Advisory Board of the hospital, was authorized by the board to consider this problem. After studying the matter thoroughly the committee recommended that the hospital administration establish a program whereby fees for hospital care and for medical and surgical services would be collected from this class of non-indigents. It was further recommended that such fees should not be paid to the individual staff physicians rendering the services, but placed in a special research fund to be administered jointly by members of the two medical schools. It was advised that non-members of the staff of the hospital be not permitted to care for patients in the hospital because of administrative difficulties and interference with the program for training medical students, interns and resident physicians. The recommendations of the committee were adopted by the Medical Advisory Board without any dissenting vote.

Pursuant to the adoption of this report a special committee on fee schedule was appointed with Dr. Walter A.

Bayley as chairman. This committee held several meetings and received suggestions from many different sources. Its report was approved by the Medical Advisory Board on June 15, 1944, and the hospital administration was requested to establish the fiscal mechanism for collecting such fees and allocating them to the special committee in charge of the research fund, which will be known as the "Medical Research Fund of the Los Angeles County General Hospital." Dr. Burrell O. Raulston, dean of the University of Southern California School of Medicine, and Dr. W. E. Macpherson, dean of the College of Medical Evangelists have been named co-chairmen of the research committee which will administer the fund.

At the conjoint meeting of the medical and surgical staffs of the General Hospital which was held on Monday, June 26th, Dr. Bayley presented the work of his fee schedule committee with a statement that it had been approved by the Medical Advisory Board. After some discussion, the proposal was unanimously approved by the staff. The attendance at the meeting was not large but the action taken can probably be regarded as indicative of the staff membership as a whole.

The Fee Schedule:

General Medical Care—$5.00 per day with certain limitations by the hospital management upon this fee when a patient is confined for an unusually long time in the hospital.

Surgical Fee—Surgical and obstetrical procedures are to be classified into major and minor operations, and, in turn, major and minor operations are subdivided into groups A, B, C, and D:

Major Operations		Minor Operations	
A	$250.00	A	$100.00
B	200.00	B	75.00
C	150.00	C	50.00
D	100.00	D	25.00

A special stamp bearing the classification Major or Minor A, B, C, D, will be furnished by the hospital and imprinted upon the operative record of each patient. Following an operation the surgeon in connection with his dictation to the surgical stenographer will merely dictate his classification of procedure; that is, a difficult laparotomy such as gallbladder, resection of stomach or intestinal anastomosis, would be classified as Major A. It is believed that all procedures within the hospital can be appropriately classified in this manner. It is believed that the committee's plan to use this simple classification will be much easier in practical application than a fee schedule.

It has been suggested to the hospital management, and Mr. Leroy R. Bruce, superintendent, has agreed to comply with this suggestion, that a brochure be prepared setting forth the fact that staff members are not profiting directly from payment for these services, but that the entire community can be expected to derive benefit from a carefully supervised program research in the hands of qualified men such as Doctors Raulston and Macpherson. It is further suggested that this brochure might appropriately point out that members of the Los Angeles County Medical Association for years have freely given their time and services to the indigent poor of this community and will continue to do so.

A few words of comment may be in order concerning the general philosophy underlying this program. There was some thought on the part of the hospital management that the schedule as outlined is too high. The fee schedule committee felt very strongly that this schedule should represent only a reasonable minimum fee for the procedures contemplated. It must be borne in mind that once such a schedule is used it is quite likely to be quoted in court procedure as a basis for establishing the value of medical and surgical services and thus, it should not be too low. It was understood that when such a schedule imposes hardship upon any patient the hospital management will not press for collection. Certainly the rendering of a bill covering medical care will serve the salutary purpose of informing a patient that services of value have been rendered. It is doubtful that legal attempts at collection will be made or would be desirable.

As far as the writer is aware this is the first instance in which a plan of this kind has been put into operation in a county hospital. Since circumstances have forced such a situation upon the institution certain safeguards seem essential. It is believed that these safeguards have been adequately established. The hospital staff is to be commended for its generous attitude. The people of Los Angeles should know what these doctors of medicine are doing to help relieve the hospital bed shortage. It is to be hoped that the hospital management will see that the press has adequate information from time to time concerning this work.—E. T. Remmen, Secretary, Los Angeles County Medical Association.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Medical Service Principles as Outlined by the Conference of Twenty-six Governors.—On August 4th a statement of policy was adopted by 26 Governors and the conclusions reached at the end of their parley contained, among other items, several that have relation to the public health.

In nonpartisan spirit, and in order to acquaint members of the medical profession with the pronouncements of one of the two great political parties of the United States, the following excerpts are printed. In case the representatives of the Democratic party pass resolutions on the same topics, it follows that space will be given thereto. The planks in the Democratic and Republican platforms relating to public welfare and health matters appeared in the August issue of California and Western Medicine, on page 113.

Quotations from the Governor's Conference follow:

"In achieving these objectives, the following principles should be observed:

"1.—The States and the local communities should improve their existing hospitalization, clinical treatment, visiting nursing and other public health programs, as far as their resources permit.

"2.—There should be no political control of the profession of medicine.

"3.—The existing scattered federal agencies concerned with various aspects of the public health, should be more closely integrated."

* * *

"Great efforts have been made by our communities, the States and the Federal Government to protect and improve the public health. The recent medical examination by our draft boards and military authorities of men and women applying for admission to the military and auxiliary forces or subject to the draft, however, have revealed deficiencies in the health of our Nation. In the face of these findings, as soon as the war is over, measures should be taken for a more effective improvement of the people's health."

* * *

"The administration of public welfare programs belongs primarily to the States and communities. Local, State and Federal Governments should provide educational opportunities for all citizens, but control of free public schools should remain in the states and cities.

"There must be no political control of the medical profession."

MATERNITY-PEDIATRIC PLAN OF FEDERAL CHILDREN'S BUREAU*

Special C.M.A. Committee on Maternity-Pediatric Care

Karl L. Schaupp, M.D., Chairman, San Francisco

Northern Group:

Karl L. Schaupp, M.D., Chairman, San Francisco
Lawrence Jacobus, M.D., Oakland
Mast Wolfson, M.D., Monterey
John W. Sherrick, M.D., Oakland
George H. Kress, M.D., Secretary, ex-officio, San Francisco

Southern Group:

Donald G. Tollefson, M.D., Chairman, Los Angeles
William B. Thompson, M.D., Hollywood
E. O. Raulston, M.D., Los Angeles
Charles G. Curtis, M.D., Brea
Sam J. McClendon, M.D., San Diego

* * *

ITEM LVI

"Form M" of E.M.I.C.

(Note. This is the preliminary draft of a proposed revision of former "Form M".) This is reverse side of patient's application—Tentative Preliminary draft of June 10, 1944, as submitted by C.M.A. Committee.

Physicians' Request for Authorization for Medical Services For Maternity Patient

I request authorization for payment to be made by the California State Department of Public Health in accordance with the regulations and the fee schedule of the Emergency Maternity and Infant Care Program for services to be provided by me to the applicant from

....
Date application signed.

Indicate with a check mark which service you request to be authorized:
Prenatal Care ☐ Delivery and Postpartum Care ☐ Postpartum Care Only ☐

I have made a reservation for the applicant at........
..............Hospital ....
Address

Expected date of confinement....................

Month of pregnancy...................

Date .... Signature ....

Conditions of Payment

1. A single fee has been established for all services provided by the attending physician during the prenatal, labor and postpartum period (6 weeks following the termination of pregnancy) to include office treatment of intercurrent conditions not attributable to pregnancy and care of the newborn infant for 2 weeks.

2. A supplementary authorization will be issued upon request for services to be provided by the attending physician for treatment of major illness, including surgery, which requires care either in the home or in the hospital.

3. Separate authorizations for consultation, diagnostic procedure and ambulances will be issued upon request.

4. When the physician does not attend the delivery or does not render services customarily considered to be a part of maternity care, or when the patient applies late in pregnancy, or at the time of delivery, the fee for maternity service will be prorated accordingly.

MATERNITY-PEDIATRIC—ITEM LVII

OFFICIAL NOTICE†

Subject: County Society Maternity-Pediatric Committees. Recent Rulings of E.M.I.C. on C.M.A. Suggestions

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, San Francisco 8
San Francisco, August 31, 1944

The C.M.A. County Medical Societies, Addressed.
Attention:
(Name) County Medical Society.

Dear Doctors:

During the last year, CALIFORNIA AND WESTERN MEDICINE has given much space to the important subject of E.M.I.C. (Emergency Maternity Infant Care) program of the Federal Children's Bureau.

The August issue, on page 72, contains an illuminating article by Dr. William Benbow Thompson of Los Angeles, whose reports to the C.M.A. House of Delegates appeared in the June issue of C. and W. M. on pages 295 and 305. In the August issue, items also on pages 114-116.

This present letter is written to call attention to action taken by the C.M.A. Council at its 320th meeting held on August 6, 1944. Excerpt follows:

"8. *Maternity-Pediatric Program of Federal Children's Bureau:*

"Reference was made on Washington, D. C., conferences of Dr. William Benbow Thompson, of Los Angeles, who represented the special C.M.A. committee, and of Dr. Jessie Bierman, Chief of the Bureau of Maternal and Child Welfare of the California State Board of Public Health, who had attended a more recent conference with Federal Children's Bureau Officials in Washington, D. C.

"The increased responsibilities of physicians, through faulty phraseology in the 'Form M' contract of E.M.I.C. were discussed. The suggestions concerning consultants, supplementary fees, and other items as brought out in the reports by Dr. Thompson, also received consideration. (See CALIFORNIA AND WESTERN MEDICINE, for August, on page 72.)

"Upon motion made and seconded, it was voted that the Special C.M.A. Committee on Maternity-Pediatric Work be authorized to communicate with component county societies and to urge each county society to appoint a Special Maternity-Pediatric Committee that could work with and through the C.M.A. Committee on Maternity-Pediatric Work in order to promote objectives best suited for local and other needs, and in line with plans approved by the C.M.A. Committee and Council."

The enclosed addendum gives information concerning the action of the Federal Children's Bureau on suggestions recently submitted by the C.M.A. Committee on Maternity-Pediatric Work.

In case your county society has not appointed a Committee on Maternity-Pediatric Care, say of 3 or 5 members, you may wish to take action.

If a committee is appointed, kindly send names of members to the Central C.M.A. Office (Reply blank and envelope are enclosed.)

The State Committee will endeavor to inform component county units concerning any new developments.

Cordially yours,
C.M.A. Committee on Maternity-Pediatric Care.
KARL L. SCHAUPP, M.D., *Chairman.*
By GEORGE H. KRESS, M.D., *Secretary.*

* * *

Addendum

(Action of Federal Children's Bureau on Recommendations Submitted by the Maternity-Pediatric Committee of the California Medical Association. (For reference, see note at bottom of page 75 in August CALIFORNIA AND WESTERN MEDICINE.)

1. *Provision whereby the patient may supplement the fee paid from E.M.I.C. funds.*

Disapproved.

(Since there is some question of the legality of this under the current legislation, negotiations will not be carried further at this time by the California State Department of Public Health.)

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* Maternity-Pediatric items listed in Roman numerals. CALIFORNIA AND WESTERN MEDICINE for July (Items I to XVIII); September, pages 178-182 (Items XIX to XXIII); October, pages 226-231 (Items XXIV to XXX); November, pages 282-284 (Items XXXI to XXXVII); December, page 342 (Items XXXVIII and XXXIX and page 304), January, pages 31-32 (Items XL and XLI); February, pages 76-77 (Items XLII and XLIII); March, page 110 (Items XLIV and XLV); April, page 221 (Item XLVI); May, page 259 (Items XLVII to LI); July, page 34 (Items LII to LIII); August, page 114 (Items LIV to LV).

† *For explanatory editorial comment, see page 129.*

The supplementary fee (from patients able and willing to pay) was disapproved on the basis of the intent of Congress, availability of funds and impracticability of variations in fees according to geographic areas except on a basis of "objective criteria," such as the cost of living and the quality of service.

2. *Elimination of the requirement of a minimum of five prenatal visits to secure payment of the $50 E.M.I.C. maternity fee.*

Disapproved.

(Negotiations to be continued.)

3. *Provision for additional payment to the attending physician for special diagnostic procedures and Caesarean sections.*

Disapproved.

(Counter proposal by State Department of Public Health for payment of $50 for abortion or miscarriage is being made.)

4. *More liberal qualifications of consultants.*

Approved.

5. *Minor change in wording of section which provides for referral of newborn infant for routine care which allows any practitioner who does not customarily provide such care to refer the infant to a pediatrician.*

Approved.

6. *Revised from M, as submitted by California State Board of Health, with the exception of those clauses which provide for supplementation of fees.*

Approved.

Subject: Prescriptions for Extra Allocation of Rationed Foods—County Food Committees

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, San Francisco 8

San Francisco, August 30, 1944.

The C.M.A. County Medical Societies, Addressed.
Attention:
County Medical Society.

Dear Doctors:

Recommendation was recently received from Governmental authorities, asking that prescriptions for heavy cream, sent in by local boards of War Food Administration, be countersigned by local health officers and county society secretaries.

To throw such responsibility on these two officers could lead to embarrassing situations.

* * *

Concerning the request for countersigning by local health officers, the California State Board of Health, at its meeting on August 23rd, took the action indicated in the copy of the State Board's letter of August 22nd.

In line with the action taken by the California State Board of Public Health, the suggestion is made that each County Medical Society appoint a local food committee, with or without the County Society secretary a member thereof.

Requests for approval of prescriptions for extra allotments of rationed foods could be referred to such committee for recommendation.

In the July CALIFORNIA AND WESTERN MEDICINE, on page 47, appears an item on "O.P.A. Food Rationing," on system in operation in San Francisco.

Upon request, the Food Committees of the San Francisco and Los Angeles County Medical Associations will probably be glad to give further information concerning their methods of procedure.

Cordially yours,
PHILIP K. GILMAN, *Council Chairman.*
GEORGE H. KRESS, *Secretary-Editor.*

(Addendum to Letter, dated August 30, 1944)

(COPY)

State of California
DEPARTMENT OF PUBLIC HEALTH
San Francisco

August 22, 1944.

To All Health Officers:

Order WFO-13, Amendment 2, of the War Food Administration has been called to the attention of the State Board of Public Health.

This order calls for the approval of physicians' prescriptions for heavy cream by the local health officer or Secretary of the County Medical Association.

The Board has carefully considered this problem—and points out the following facts:

1. The need of patients for heavy cream, if it exists, can be determined only by careful clinical and laboratory observation.

2. The determination can be made only by a skilled internist with the aid of a well-equipped laboratory.

3. The health officer ordinarily does not have these facilities at his disposal.

It is, therefore, suggested that it would be unwise for health officers to take the responsibility for either approving or disapproving the recommendation of the practicing physician in this regard, and that prescriptions of this type be regularly referred to the food committee of the County Medical Association. The Secretary of the County Medical Association can give information regarding this committee.

(Signed) STATE BOARD OF PUBLIC HEALTH.

Nebraska Law re: Professional Degrees

The item which follows, appeared in the *Journal of the Kansas Medical Society* for June, on page 212:

NEBRASKA MEDICAL PRACTICE ACT

The following information was furnished by Dr. C. E. Joss of Topeka, president of the Kansas State Board of Registration and Examination:

The Nebraska Legislature in 1943 amended the Medical Practice Act, and the following sections are of general interest, particularly in the present action of the various cults in their attempts at recognition as medical practitioners:

"Sec. 71-206. Every person, licensed under this act to practice a profession, shall keep such license displayed in the office or place in which he or she practices and place and keep placed, in a conspicuous place at each entrance thereto, a sign, in intelligible lettering not less than one inch in height, containing the name of such person and immediately followed by the recognized abbreviation indicating the professional degree, if any, held by such person. In addition to the foregoing, those persons licensed to practice osteopathy, chiropractic, chiropody or optometry shall cause to be placed upon such signs, a lettering of equal height, the word, 'Osteopath,' 'Chiropractor,' 'Chiropodist' or 'Optometrist,' as the case may be; Provided, further, the same wording shall be used in all signs, announcements, stationery and advertisement of such licensees."

Whenever a license is suspended by any licensing body, the case may be heard by right of appeal to the district court calendar over all other cases except compensation and criminal cases. . . .

The Board reserves to itself the right to accredit medical colleges, fixing the standards for such medical schools; the application is to be made by the school, it being necessary that such be accepted by the State Board before any graduates of such schools may obtain a license. In Part 11 of this section an osteopathic college may be also accredited if it fulfills the minimum requirements.

Gull's Disease.—"The road to medical education is through the Hunterian Museum and not through an apothecary's shop," is one of the clever epigrams coined by William Withey Gull. Besides possessing wit, he was urbane and genial, qualities that appealed to patients and pupils alike. But his authoritative manner and occasional temper sometimes irked his colleagues. He was numbered with Wilks and Hilton Fagge among the most prominent clinicians and pathologists at Guy's Hospital.—Warner's *Calendar of Medical History.*

COMMITTEE ON ASSOCIATED SOCIETIES

Medicine and the Law—Re: Malpractice

In the *"Bulletin of the Los Angeles County Medical Association,"* of July 20, the secretary-editor, Dr. E. T. Remmen, presented the following pertinent comments on the need of better understanding of malpractice litigation:

Among the varied activities of the Los Angeles County Medical Association, none exceeds in importance its energetic campaign to reduce the number of malpractice suits brought against physicians. The effort has already had a large measure of success, for which we owe a debt of gratitude to our good member and legal counsel, Dr. Louis J. Regan. Without compensation of any kind, Dr. Regan has attended almost every trial of a malpractice action during the past seven years. His advice to our members when threatened with such suits has been invaluable. His lectures and writings on malpractice prophylaxis have attained national recognition. It is a well known fact that most malpractice actions possess very little merit. Many suits are brought by attorneys who have either been misinformed by their clients as to the facts, or who hope to obtain a fee through a compromise settlement. Physicians themselves have unwittingly done much to encourage such suits, through thoughtlessness and careless comment not only to their own patients, but to patients who have been treated by other doctors.

It will be recalled that a series of lectures on malpractice and other medico-legal subjects was presented last spring in the Association's auditorium. This series was arranged by Dr. Regan. Speakers included prominent judges, officials, and attorneys. The subjects, naturally, were approached from the legal and judicial viewpoint. The material presented was of great value to the physicians who attended and to those who read the abstracts subsequently published in the Bulletin.

In the knowledge that these matters are also of deep concern to the legal profession, our committee on malpractice, Doctors Regan, Fred B. Clarke, and J. Severy Hibben, in coöperation with a committee from the Los Angeles Bar Association, Messrs. Murray F. Keslar, John P. McGinley, and Elbert H. Tilson, are arranging a series of programs, to begin in September and to be presented by the Los Angeles County Medical Association.

It is planned that each section of the Association will present one evening's program with one or more speakers, as the section may elect. The problems of each specialty, as they relate to malpractice litigation, will thereby be covered from the medical viewpoint. The discussions, accompanied by motion pictures when possible, should prove interesting and instructive to the local bench and bar as well as to personnel of the various law enforcement offices.

* * *

The lectures to which reference was made include the following:

A program is now being arranged by a joint committee composed of three members of the Los Angeles Bar Association and three members of the Los Angeles County Medical Association: Messrs. Murray F. Keslar, John P. McGinley and Elbert H. Tilson, and Drs. Fred B. Clarke, J. Severy Hibben and Louis J. Regan.

Each major section of the Los Angeles County Medical Association will be responsible for one evening's presentation. It is primarily intended that the material selected and the method of presentation shall be interesting and understandable to attorneys. Motion pictures, slides and other illustrative means will be freely used. It is planned that there will be opportunity for questions from the floor on the occasion of each meeting.

The series of presentations, beginning in September, will be concluded about the middle of December. Full details, with dates of these meetings will be announced shortly. The tentative program:

The Doctor Speaks to the Attorney:

1. Problems of the Surgeon
2. Problems of the Internist
3. Problems of the Obstetrician
4. Problems of the Radiologist
5. Problems of the Industrial Surgeon
6. Problems of the Eye and Ear Specialist
7. Problems of the Neuropsychiatrist
8. Problems of the Orthopedic Surgeon
9. Problems of the Urologist
10. Problems of the Tuberculosis Specialist
11. Problems of the Dermatologist
12. Problems of the Pathologist
13. Problems of the Pediatrician

* * *

Los Angeles County Medical Association Opens Medical Legal Symposium on Friday, September 22

A symposium of far-reaching significance is being presented this fall under the joint auspices of the Los Angeles Bar Association and the Los Angeles County Medical Association.

Because of interest evidenced by members of the Bar Association in the thirteen Friday evening programs that have been arranged, the lodge room of the Elks Club at 607 South Park View Street (opposite Westlake Park) has been reserved for these meetings. The lodge room has a seating capacity of one thousand.

This symposium is developed by a joint committee of the Bar Association and the County Medical Association and represents one of the most important steps ever taken anywhere in the country to improve and to expand public relations in a most significant and constructive manner.

The first program will be presented Friday evening, September 22, beginning at 8 o'clock sharp, and each Friday evening thereafter including November 24. There will be no program on Friday, December 1. The remaining two programs will be presented on December 8 and 15.

Round table discussions will be held at each meeting following the presentation of the formal program. These round table discussions will be opened by a representative of the bench or the bar who will be well qualified to correlate the medical and legal factors under consideration.

Special invitations are being sent to the justices of the Supreme Court of California, to the judges of the federal courts in this area, to the judges of the second and fourth appellate districts (California), and to all local superior and municipal court judges. Special invitations also are going forward to all attorneys attached to federal, state, county and city bureaus and agencies who may come in contact with Doctors of Medicine either directly or indirectly.

A careful review of these programs, together with an understanding of their great significance, makes it evident that our profession is presented with an unexcelled opportunity. The symposium will have much to offer in the way of instructive material to every practicing physician. Months of work have gone into the project to perfect it and to make it interesting and instructive to doctors and attorneys alike.

All members are urged to plan now to attend.

Program follows:

"THE DOCTOR SPEAKS TO THE ATTORNEY"

Program of Medico-Legal Symposium

Friday, Sept. 22, 8:00 p.m.

Problems of the Internist. Exhibits, motion pictures.
Speakers: Gurth Carpenter, M.D., Paul M. Hamilton, M.D., Burrell O. Raulston, M.D.

Friday, Sept. 29, 8:00 p.m.

Problems of the Eye, Ear, Nose and Throat specialist. Exhibits, slides, motion pictures.
Speakers: William A. Boyce, M.D., J. Mackenzie Brown, M.D., John N. Osborn, M.D., Pierre Viole, M.D.

Friday, Oct. 6, 8:00 p.m.

Problems of the Neuropsychiatrist. Exhibits, slides, motion pictures.
Speakers: Samuel D. Ingham, M.D., Glenn E. Myers, M.D., J. M. Nielsen, M.D., Rupert B. Raney, M.D.,

George N. Thompson, M.D., Karl O. Von Hagen, M.D., Eugene Ziskind, M.D.

Friday, Oct. 13, 8:00 p.m.

Problems of the Radiologist. Exhibits, slides, x-rays.
Speakers: L. Henry Garland, M.D., Lowell S. Goin, M.D., Douglas R. MacColl, M.D.

Friday, Oct. 20, 8:00 p.m.

Problems of the Pathologist. Exhibits and slides.
Speakers: E. M. Butt, M.D., Alvin G. Foord, M.D., Roy W. Hammack, M.D.

Friday, Oct. 27, 8:00 p.m.

Problems of the Surgeon. Exhibits, slides, motion picture (appendectomy).
Speakers: E. Vincent Askey, M.D., J. Norton Nichols, M.D., Harold L. Thompson, M.D.

Friday, Nov. 3, 8:00 p.m.

Problems of the Pediatrician. Exhibits, slides, other illustrations.
Speakers: Milo B. Brooks, M.D., Howard R. Cooder, M.D., C. Morley Sellery, M.D.

Friday, Nov. 10, 8:00 p.m.

Problems of the Industrial Surgeon. Exhibits, slides, motion pictures.
Speakers: Benjamin Frees, M.D., Jerome W. Shilling, M.D., William L. Weber, M.D.

Friday, Nov. 17, 8:00 p.m.

Problems of the Tuberculosis specialist. Exhibits, slides, motion pictures.
Speakers: Frank S. Dolley, M.D., C. R. Howson, M.D., J. J. Singer, M.D., Reginald H. Smart, M.D.

Friday, Nov. 24, 8:00 p.m.

Problems of the Urologist. Exhibits, slides, motion pictures.
Speakers: J. J. Crane, M.D., Tracy O. Powell, M.D., Gilbert J. Thomas, M.D.

Friday, Dec. 8, 8:00 p.m.

Problems of the Dermatologist. Exhibits and lantern slides.
Speakers: Samuel Ayres, Jr., M.D., Arthur Fletcher Hall, M.D.

Friday, Dec. 15, 8:00 p.m.

Problems of the Orthopedic Surgeon. Exhibits, slides, x-rays, motion pictures.
Speakers: Alvia Brockway, M.D., Harold E. Crowe, M.D., Hugh Toland Jones, M.D., Charles L. Lowman, M.D., Samuel S. Mathews, M.D., Edwin B. Plimpton, M.D., Ward M. Rolland, M.D., John C. Wilson, M.D.

Southern California Public Health Association

MEDICAL CARE IN THE FUTURE

Dawn of a new era in public health was forecast at Pasadena on June 1, 1944, by Dr. William P. Shepard, San Francisco, who spoke before the Southern California Public Health Association conference.

Approximately 400 doctors, nurses and social workers from the entire Southland area were in attendance at the two-day conference. Conferenec sessions were presided over by Dr. John F. Kessel, president of the association, and professor of Bacteriology and Parasitology in the U. S. C. School of Medicine.

The Southern California Section, National Association of Sanitarians, Inc., held a meeting in conjunction with the Public Health Association and concluded with a dinner meeting at 7 p.m. June 2 at the Athletic Club, with George M. Uhl, Los Angeles City Health Officer, as chairman.

Dr. Shepard, who is affiliated with the Metropolitan Life Insurance Company, said the keynote for new trends in public health is set first of all by the substitution of highly trained health officers for the old-time ill-trained and poorly supported ones.

He said changing trends in medical care are being brought about by the fact that people find it impossible to save for sickness. While in the past the economic ability to pay rather than need has determined the practice of the private physician, Dr. Shepard sees for the future a program of sound public health work participated in by the private physician who, he said, "will never disappear entirely." He said many physicians themselves favor such a plan, because "medicine has become a priesthood which has been far from satisfactory to them."

The speaker said these changes will come about through a "process of local and national natural growth. States and counties, cities and villages must learn as they go to secure good medical care wherever needed. A sound program must be based upon free choice of a physician by the patient, ready consultations, complete equipment and facilities.

"In future as result of better medical and health practices there will be less dependency, less unemployability, less bereavement and in general an enriched community life. Also, the population age is to be increased by approximately 20 years.

"This nation, which has always been one of young people, will become a nation of older persons, with more than half of the population exceeding 45 years of age. But I feel hopeful that widespread old age dependency can be avoided, although there will be a great need for more mental hygiene, especially in the form of hobbies."

Dr. Arthur Massey, health officer for Coventry, England, also spoke on the evening program. He said the general health of the people of England in all classes had been better since the war than before it.

"There has been a peculiar absence of influenza although we have been apprehensive of an epidemic ever since the war started. There has been some wartime increase in tuberculosis due to strain of war work, lack of ventilation caused by black-outs and use of shelters."

Dr. Kessel addressed the afternoon session on "Tropical Diseases" and pointed out their relation to the current war. He said there is danger of these diseases being brought in by people and also by insects, but that rigid inspection, and spraying of planes and ships is reducing danger from the latter. "We view this problem with concern but not with alarm," he said.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

"Model" Bill Revives Anti-Science Campaign

This is about the newest effort to revive a perennial agitation for the superstition that scientific experimentation on animals is "torture," to be prohibited on dogs, though not on other animals. Even on dogs it is opposed only when done in laboratories for scientific research.

The immediate instance is an editorial in the Washington, D. C., *Times-Herald*, exhuming a bill long forgotten in the files of a Congress committee and demanding "action" on it.

This Washington demand is now reprinted prominently on the editorial pages of other affiliates of the *Times-Herald's* chain and thus attains a much more widespread circulation. If persisted in it could stir up efforts for similar action by State Legislatures. Thus it might become, as it has done before, a practical issue in California, to be met when and if it occurs, and to be warned against now.

This "model" bill for the District of Columbia is of the usual anti-science sort. Its ostensible sponsors are Representative Burton and Senator Langer, both from North Dakota, a State where there is no such issue, nor any particular interest in it. Obviously it is just one of those bills put in good naturedly "by request," because somebody asked it, and promptly shelved. The only new thing that has happened is this editorial agitating to revive it, which is now given addition publicity in various States. Today is, therefore, the appropriate time to call attention to it and then to drop the subject unless and until it is again made an active issue in California.

The bill in question is the stock one, opposing not "cruelty," but science. Since this anti-science dogma is contrary to fact, not derived from evidence nor amenable to reason, it is futile to argue with its closed-mind fanatics, and one normally avoids even mentioning it, except when something like this renewed newspaper agitation makes a direct public challenge.

When that did happen before, in California, it called for counter action, led by the universities, in which this writer, speaking in part as a Regent for the State University, and in part as a lay representative of the California Medical Association, found himself thrust into rather strenuous participation.

If this column can help avoid that beforehand, it will have been worth the bother, including even the usual excited protests.

Says the Washington paper, after quoting the bill:

"Such a law as the above is certainly necessary to protect helpless dogs from cruelty practiced in disguise as science."

"Cruelty to animals leads all too easily to cruelty to men, and there is more than enough of that already. There is no national law against cruelty to animals. There should be. Let us make a beginning toward it by passing the above quoted act for the District of Columbia."

Unfortunately the "above quoted act" does not prohibit cruelty to "animals." Horses and cattle are surely "animals," and it forbids nothing as to them. And what it seeks to prevent, even as to dogs, is not cruelty, but scientific investigation. Here is its exact language:

"It shall be a misdemeanor for any person to experiment or operate on any living dog, for any purpose other than the healing or curing of said dog."

This would bar obtaining serum from dogs recovered of distemper to protect other dogs from it. The same principle applied to humans would also stop blood donors from their current contributions to save the lives of other men wounded in war. It would make impossible the production of the antitoxins and vaccines now compulsory in the armed forces.

Moreover, if there is "no national law against cruelty to animals," it is for the same reason that, except for the federally administered District of Columbia, there also is no "national" law against murder, burglary, robbery or rape. These are all offenses constitutionally reserved to the police power of the States.

The Washington paper's editorial, therefore, plus the current reprints of it, is as ignorant of law as it is of science, and is irrational as to both.

Finally, the proposed measure would not protect even dogs against "cruelty." It would remain lawful to castrate them, or chop off their tails, without anesthetic, or, unless prevented by State laws, to pit them against bears, bulls or other dogs, for human amusement.

But it would prohibit testing foods or remedies on dogs, before using them on human patients. And cattle could continue to be dehorned or gelded, without anesthetic.

Against "cruelty"—bah! It is against the advance of human knowledge, and its use to save lives and suffering, for men and for animals.—Chester Rowell in San Francisco *Chronicle*, August 14.

(Ed. Note.—Physicians who are interested in the subject of anti-vivisection, should refer to two articles by Professor A. C. Ivy of Northwestern University Medical School, printed in CALIFORNIA AND WESTERN MEDICINE in year 1934 in October issue on page 247, "Some Contributions by Animals to Human Health," and in November numbers, on page 325, "Seven Wonders of Medical Science—Modern Miracles.") See also *J.A.M.A.*, Sept. 9, 1944, p. 102, for article, "The Chicago Anti-Vivisection Furor."

Prostitution and Delinquency Problems

Conference Between State Bar of California and California Medical Association Committees

Mr. Jerold E. Weil,
Secretary of the State Bar of California,
San Francisco 3, California.

Dear Mr. Weil:

In August of 1943 I received a letter from you notifying me that the Board of Governors had referred to the Southern Section of the Committee on the Administration of Criminal Justice for study, report and recommendation to the Board a matter that was initiated with the Board of Governors by a letter under date of July 13th from Dr. Phillip K. Gilman, addressed to Mr. Frank G. Belcher, President. Dr. Gilman's letter to Mr. Belcher enclosed a copy of a letter from Dr. Thomas Parran, Surgeon-General of the United States Public Health Service, and Dr. Gilman called attention to the fact that Surgeon-General Parran requested the California Medical Association to acquaint Mr. Belcher with the personnel of its committee dealing with prostitution and delinquency problems.

The committee consists of:

Captain John C. Ruddock, MC, U.S.N.R., 411 West 5th Street, Los Angeles.
J. C. Geiger, M.C., 101 Grove Street, San Francisco.
C. M. Birchfield, M.D., 311 S. 1st Street, San Jose.

The purpose of this correspondence was to bring about some kind of coöperation between the California Medical Association and the State Bar of California in connection with the subject matter mentioned in Dr. Gilman's letter. Very shortly after the matter was referred to my attention, I endeavored to contact Captain John C. Ruddock, the Chairman of the California Medical Association Committee." . . .

. . . Following the conference between Captain John C. Ruddock and myself, Captain Ruddock sent to me a copy of his proposed report as Chairman of the Executive Group Committe on Health and Public Instruction of the California Medical Association. In this report Captain Ruddock had the following to say with respect to the matter of our conference:

"Liaison with the California State Bar Association with Regard to Solving the Problem of Prostitution and Delinquency as It Affects the Venereal Disease Control Program as Outlined by the Surgeon-General of the U. S. Public Health Service.

"Your chairman has met with Mr. Michael F. Shannon, Esq., Chairman of the Southern Section of the Committee to investigate the administration of Criminal Justice of the California State Bar Association. This matter was referred to this committee by the Board of Governors of the State Bar Association.

"A communication on January 8, 1943, from the Surgeon-General to the Secretary of the California Medical Association, suggested that a meeting would be held in order to formulate suggestions and recommendations for a coördinated effort of venereal disease control by the Medical Profession and the State Bar Association. Your chairman was selected by the Council of the California Medical Association for this meeting. All matters pertaining to venereal disease control were thoroughly discussed and the following agreements were made:

"The Chairman, Mr. Michael F. Shannon, Esq., agrees to make the following recommendations to the California Bar Association:

1. That the California State Bar Association recognize the problem of venereal disease control in the State of California as regards the civilian and military personnel and further recognizes the fact that the source of venereal disease is in the civilian population;
2. That a close liaison be maintained by the local bar associations and the lawyers and public health enforcement agencies;
3. *That the California State Bar Association invite* the California State Medical Association to submit any recommendations for change in the present statutes or any legislation for review, in order that a coördinated, coöperative movement may be instigated for accompanying such changes;
4. That the California State Bar will review, after receiving such problems, the various statutes as pertaining to venereal disease control, towards effecting such changes as will solve the prostitution and delinquency problems affecting this program. It is suggested that the Council of the California Medical Association instigate through the office of the Secretary such recommendations as would enable the completion of such a liaison between the California Medical Association and the California Bar Association."

Agreeable to the statement in Captain Ruddock's report, I do make the recommendations to the Board of Governors set forth in Captain Ruddock's report.

Respectfully,
(Signed) MICHAEL F. SHANNON
Chairman, Southern Section
of the Committee on the
Administration of Criminal
Justice.

Kenny Poliomyelitis Claim Denied

A charge that the public and many doctors have been misled by publicity about the infantile paralysis treatment of Sister Elizabeth Kenny, famous Australian nurse, was recently made to the American Medical Association at Chicago in a report by seven university professors, all physicians.

They also said they acknowledge that the Kenny publicity has stimulated the medical profession to more effective treatment.

The seven were appointed two years ago this June to evaluate the Kenny treatment by the orthopedic section of the American Medical Association and by the American Academy of Orthopedic Surgeons and the American Orthopedic Association.

"There is no evidence," the report said, "that the Kenny treatment prevents or decreases the amount of paralysis. We criticze severely the oft repeated statement of Miss Kenny to patients who have come to her after treatment elsewhere that had this case come to her early the disability would have been prevented. Such statements are not founded on facts.

"Spontaneous recovery in poliomyelitis occurs in many cases. Reports in the medical literature indicate that this varies in different epidemics from 50 to 80 per cent. We have seen many patients receiving the Kenny treatment who showed no muscle involvement at any time, yet she assumes credit for their satisfactory results and does not take into account the factor of spontaneous recovery."

In another place the report said: "Miss Kenny has repeatedly stated that under 'orthodox' treatment only 13 per cent of the patients recovered without paralysis, while under her treatment over 80 per cent recover. Miss Kenny's statement of 80 per cent recovery under her treatment has not been supported by accurate statistics in a significant number of cases.

"The figure on 'orthodox' treatment is taken from an article which dealt entirely with severely paralyzed patients. Miss Kenny has been told repeatedly that this is not a fair comparison to make and that if every case in an epidemic is included in the statistics, recovery of from 70 to 90 per cent can be expected from 'orthodox' treatment. Miss Kenny made this inaccurate comparison as late as May, 1944.

"Some people using the Kenny treatment believe that paralysis can be prevented when treatment is started early enough; that is, prior to the onset of paralysis. We have seen enough cases, however, in which the Kenny treatment was instituted very early to be convinced that this does not prevent or even minimize the degree of permanent paralysis.

"While the committee disapproves of and condemns the wide publicity which has misled the public and many members of the medical profession to reevaluate known methods of treatment of this disease and to treat it more effectively."

The committee in its study visited six cities and 16 clinics, where more than 740 patients were examined, of whom approximately 650 had been treated by the Kenny method.

The committee members are Doctors Ralph K. Ghormley, University of Minnesota Postgraduate School, chairman; Edward L. Compere, University of Illinois College of Medicine; James A. Dickson, Cleveland Clinic; Robert V. Funsten, University of Virginia Department of Medicine; J. Albert Key, Washington University School of Medicine, St. Louis; H. R. McCarroll, Washington University School of Medicine, and Herman C. Schumm, University of Wisconsin Medical School and Marquette University School of Medicine.

Botulism in California

Botulism is a highly fatal form of food poisoning caused by botulinus toxin which accumulate in insufficiently processed home canned non-acid foods. Forty per cent of all botulism outbreaks in the U. S. and Canada have occurred in California.

In 1925 the canning industry of California voluntarily imposed restrictions and supervision on all of its products to prevent botulism. Since 1925 not a single case of botulism has been traced to commercially canned products under California supervision. In the majority of instances, botulism has resulted from home canned products.

Botulism may be prevented by the following rules:

1. When canning, follow directions in the official state canning bulletin. ("Home Canning" Bulletin H.D. 417, available at L. A. City Health Department, 116 Temple Street, Los Angeles 12.)

2. For vegetables and meats, use a pressure cooker with an accurate pressure gauge, or

3. If you cannot obtain a pressure cooker use the acid brine method (Bulletin No. 417) or dehydration.

4. Before serving vegetables or meats which have been home canned, always *boil them twenty minutes!*—George M. Uhl, M.D., Health Officer in *Bulletin* of Los Angeles City Health Department.

"Let us, a little, permit Nature to take her own way; She better understands her own affairs than we."—*Michel de Montaigne.*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (18)

Alameda County (4)

Allen, Richard G., *Oakland*
Haumeder, Hans, *Oakland*
Lundstrom, Carl H., *Oakland*
Oldt, Mary Ruth, *Oakland*

Placer-Nevada-Sierra Counties (1)

Stauch, George G., *Weimar*

Sacramento County (4)

Clark, Gilbert, *Casper, Wyoming*
Murphy, Richard C., *Sacramento*
Stabel, J. A., *Sacramento*
Wilson, Albert C., *Sacramento*

San Diego County (5)

Heidbreder, G. A., *San Diego*
Hinshaw, Sylvester E., *Escondido*
Irwin, J. W., *San Diego*
Miller, Charles J., *Lemon Grove*
Sweeney, A. R., *La Jolla*

Santa Clara County (4)

Dingacci, A. J., *Santa Clara*
Haun, John F., *Palo Alto*
Johnson, Richard M., *San Jose*
Wilson, Leo L., *San Jose*

Transfers (5)

Calvert, E. H., from Los Angeles County to San Diego County.
Giere, Norman C., from Yuba-Sutter-Colusa County to Sacramento County.
Hughes, H. A., from San Francisco County to San Diego County.
Iseminger, Sidney W., from San Francisco County to Sacramento County.
Smith, Lloyd E., from San Benito County to Santa Clara County.

Retired Members (1)

Blake, Charles Robert, *Contra Costa County*

In Memoriam

Cooper, George Proctor. Died at San Francisco, July 18, 1944, age 64. Graduate of the Cooper Medical College, San Francisco, 1906. Licensed in California in 1906. Doctor Cooper was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Haygood, Atticus Greene. Died at Downey, June 27, 1944, age 74. Graduate of the University of Nashville Medical Department, Tennessee, 1891. Licensed in California in 1891. Doctor Haygood was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Johnson, Roy Howard. Died at Los Angeles, July 24, 1944, age 66. Graduate of the University of Michigan Medical School, Ann Arbor, 1904. Licensed in California in 1911. Doctor Johnson was a member of the Los Angeles County Medical Association, and the California Medical Association.

◆

Miller, George Bernhard. (Lieutenant) United States Army Medical Corps. Died at Grass Valley, July 14, 1944, age 34. Graduate of Stanford University School of Medicine, 1935. Licensed in California in 1935. Doctor Miller was a member of the San Francisco County Medical Society, and the California Medical Association.

◆

Rhodes, George Kremer. (Colonel) United States Army Medical Corps. Died somewhere in England, July 23, 1944, age 55. Graduate of the Johns Hopkins University School of Medicine, Baltimore, 1915. Licensed in California in 1920. Doctor Rhodes was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Smith, Arthur Montell. Died at Piedmont, July 22, 1944, age 27. Graduate of the Cooper Medical College, San Francisco, 1899. Licensed in California in 1899. Doctor Smith was a Retired Member of the Alameda County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

◆

Trick, Treva Really. Died at Stockton, July 20, 1944, age 51. Graduate of the College of Physicians and Surgeons of San Francisco, 1921. Licensed in California in 1921. Doctor Trick was a member of the San Joaquin County Medical Society, and the California Medical Association.

◆

OBITUARIES

Edward Clarence Moore, M.D.
1882—1944

Edward Clarence Moore died following a long illness, at his home in Los Angeles, California, on July 10, 1944.

His spirit has departed to that haven for Professional Men, where he joined his illustrious father, his grandfather and great grandfathers; typical American physicians all.

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

At his bedside were his wife, Mrs. Ellis Moon Moore, his son Lieut. (j.g.) William Rowland Moore, U.S.N.R., his daughter, Mrs. Alexander Black, and his sister, Mrs. LeRoy M. Edwards.

These few remarks will be dwarfed to microscopic proportions by the many written and spoken tributes over the breadth of our country and especially by the editorial which appeared in the Los Angeles *Evening Herald* on July 12, 1944.

The oustanding element of greatness of Dr. Moore's character was exemplified by the manner in which he accepted the inevitable during his long illness.

Throughout this period Dr. Moore was able to remain in his own home, which was beautiful, inviting, and most restful.

Dr. Moore was educated in the elementary schools of Los Angeles and at Belmont Academy. He turned to the University of Notre Dame and the University of Southern California for his academic education, receiving the Degree of Doctor of Medicine from the College of Medicine of the latter institution in 1905. His surgical training was supplemented at the Mayo Clinic, where he served under direct supervision of Dr's. W. J. Mayo, C. H. Mayo and E. Starr Judd, as well as other prominent men of that institution.

Dr. Moore was a member of the Los Angeles County Medical Association, serving as President of this organization in 1925, and in 1914 he was honored with the Presidency of the Los Angeles Academy of Medicine (Clinical and Pathological Society). He was a member of the California State Medical Association, American Medical Association, the American College of Surgeons, the American Surgical Association. In the Pacific Coast Surgical Association, he served as President in 1934. He was active in the affairs of the American Board of Surgery, having been elected to the Founder Group of this organization. Although the operating rooms of all the accredited hospitals of Los Angeles have recorded attestations of his skill, he was an integral part of the California Hospital, this was his surgical home. For many years he was a member of the Medical Executive Board and Surgical Committee of this hospital, in which capacities he contributed freely to the conduct of the staff affairs and scientific progress.

Clarence, as he was known to most of his friends and acquaintances, Dr. Clarence, to most of his patients; "Skipper" to a few of his intimate friends of the G.P. Club; and "Elmer the Great" to his intimate Associates was vitally interested in the fish and game of the Western States, and served as President of the Fish and Game Commission of California from 1933 through 1937. His rod and reel and his guns were as much a part of him as the scalpel and forceps. They became instruments of precision in his hands. The lessons he learned from the trails and streams and God's towering peaks must have tempered and retempered his spirit.

We who have worked at his side have profited immeasurably by his skill and wisdom. We are determined to perpetuate the ideals which he clearly set forth during his long and useful life.

H. D. Van Fleet, M. D.
Donald G. Tollefson, M. D.

✣

Who well lives, long lives; for this age of ours
Should not be numbered by years, days, and hours.
—DuBartas, *Devine Weekes and Workes*, Week ii, day 4. (Sylvester, tr.)

The life given us by Nature is short; but the memory of a well-spent life is eternal.
—Cicero, *Tusculanarum Disputationum*. Bk. i, ch. 45, sec. 109.

George Kremer Rhodes*
1889—1944

"In a theatre of operations in which there has been collected the finest surgical talent in the world, Colonel George Kremer Rhodes was outstanding. He has served here with great distinction, first as the chief of the surgical service of his own general hospital, and later as the consultant in surgery to the area in which the large proportion of our battle casualties are being received. His work during the critical days in the beginning of the invasion was splendid and there are many soldiers who owe their lives to his fine judgment and his devotion to duty. His fine personality, cheerful disposition and invariable consideration of other people endeared him to all of his associates and subordinates. The young surgeons welcomed him and turned to him with their problems. . . . I shall find his replacement most difficult."

These words, from Major General Paul R. Hawley, Chief Surgeon E.T.O., U.S.A., sum up the character and attainments of our beloved colleague perhaps better than anything else that can be said.

He died in England, quietly, in his sleep, on July 23, 1944, from exhaustion brought on by his devotion to duty. He had served in World War I, first in an ambulance unit in 1916 or 1917, and later in charge of the surgical service at the Base Hospital in Camp Meade, Maryland. This experience, coupled with his long association with the San Francisco Emergency Hospital service which he joined in 1920 and his teaching experience at the University of California, made him the logical man to head General Hospital Unit 30 from that medical school. He reorganized the unit in May of 1942 and went overseas with it in June of the same year.

Early in 1942 he was selected to fill the position as Consulting Surgeon to the Southern Base Section. There his duties were arduous and much of the smoothness with which the Medical Units operated was due to his selection of the proper men to fill the key positions. Both Elliott C. Cutler, M.C., Chief Consultant in Surgery, and Col. Thomas, his immediate superior, came to depend upon him thoroughly and never questioned his judgment.

George, as he was known to his many friends, was born in Vinland, Kansas, in 1889. He received his B.S. degree from the University of California in 1912 and his M.D. degree from Johns Hopkins Medical School in 1915. He interned at Johns Hopkins Hospital on the

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* Ed Note. In this issue of California and Western Medicine, appear copies of two letters received by friends of the late Dr. George K. Rhodes. See pages 155-156.

General Surgical Service in 1915-1916. After a year with an ambulance unit in France he returned and served as Resident Surgeon and Gynecologist at the Roosevelt Hospital in New York City in 1917-1918. He came to San Francisco after his service at Camp Meade in 1920. The same year he was appointed Assistant Visiting Surgeon at the University of California Medical School and Assistant Chief of the San Francisco Emergency Service, positions he retained until he went abroad again in 1942.

He was an active member of the San Francisco County Medical Society and of the state and national societies. He was a member of the Western Surgical Society and of the Pacific Coast Surgical Society. He was also a member of Phi Chi medical fraternity and of the Commonwealth, Olympic and Bohemian Clubs.

He endeared himself to all with whom he came in contact, patients, colleagues, students, alike. His teaching of surgery, and particularly of the acute emergencies, with which he was so familiar, was very valuable and very much appreciated by his successive classes of students. His teachings will live in the work of those he taught.

He early developed an extensive private practice and in 1928 formed a partnership with Dr. Edmund William Butler which continued up to the time of his death. This long association is in itself a tribute to the fine qualities of both men.

On March 18, 1925, he married Wilma Schumacher, by whom he is survived and to whom we extend our sincere sympathy.

H. Glenn Bell, M. D.

* * *

Office of the Chief Surgeon
European Theater of Operations
U. S. Army P. O. 871,
July 27, 1944,
E C C: L j c.

Dear Mrs. Rhodes:

I wish to write you a personal note regarding George, not only because of those at home who want to know the circumstances in which his death occurred, but because in the two years in which we have been here he had become a devoted and personal friend of mine, and real friendships are not cast about lightly in this tumultuous world.

I had George moved to the Southern Base Section as consulting surgeon because it was the most difficult job we had, and it took a senior person with a high sense of responsibility, a great flair for getting on with others and a character which could be hard when necessity arose as well as pleasant for the remainder of the time. In this job George was just the person. In the first place, he got on well with people, so that his immediate boss, Colonel Thomas, a Regular Army Officer from the New England states, came to depend upon him thoroughly and never questioned anything George suggested. In the next place, he was greatly respected by all professional people because his judgment was sound and he benefited each hospital that he visited. And finally, he was an A1 example to the young men, for here was a mature citizen of their country driving himself by night and day in order that the set task of the Medical Department, i.e., the proper care of every American boy, should be of the highest order. Indeed, he performed his task so well I shall never be able to replace him exactly, though there are many American surgeons in this theater.

He awoke the morning of July 23 with a little sense of indigestion, and Lt. Col. Kneeland, his medical colleague presuaded him to rest. He lay down on his bed and Col. Kneeland went to work. When Kneeland returned in three hours George had died. His body was still warm, and the bed clothes were undisturbed, and we have the impression he died in his sleep, for which you will be equally thankful ere us. Lt. Col. Kneeland took his body to the Cambridge Cemetery, a beautiful place on a hill to the west of this University city. I have been there repeatedly, and I shall go again later and try to see if I can get a photograph of his grave for you. I have been told this is not permitted but perhaps General Hawley will allow me to do this. The autopsy proved a diagnosis of coronary closure.

General Hawley suggested that we have a short service some time, and I will try to arrange this, though his own unit, the 30th General, is on its way to Normandy. His effects will be returned to you. There is nothing more that I can say, except that I should like to die myself the same way. This is scant encouragement, but the only mortal part of man is what he has accomplished and what effect his spirit has left on civilization in which he lived. You can well be proud of what George accomplished. As I have written General Hawley, his spirit will long live to profit the officers in this E.T.O.

With this letter comes the deepest sympathy of the Division of Professional Services, for each of its members became devoted friends of George, and will sense his loss forever.

Regretfully yours,
Elliott C. Cutler, M.C.,
Chief Consultant in Surgery.

DANIEL CROSBY

1874—1944

On July 15, 1944, death suddenly came to Daniel Crosby at his home in Piedmont, California. In his passing there was lost by his family a beloved husband and father, by his friends a true and delightful companion, by his patients a skilled physician and adviser, by the physicians of Alameda County an honored professional colleague and senior statesman, and by the community at large one of its most valued public spirited citizens.

He was born at Centerville, California, September 29, 1874, to Edward Crosby and Mary Sullivan Crosby, both of Irish descent. His early schooling was received in the Centerville schools and he later graduated from the Washington Union High School, Centerville, California. Following this he taught school and was principal of the Warm Springs School.

About 1899 Daniel Crosby married Virginia Dixon. They had two children, Virginia, now the wife of James S. Bancroft, and a son, Kenneth, who died in 1915. The first Mrs. Crosby died in 1912. He is survived by his wife, Doris Glenn Crosby.

His professional career began upon his entrance into Cooper Medical College (later the College of Medicine of Stanford University) from which he graduated in 1898. While attending medical school he taught night school at the Franklin Evening School. After his graduation he interned at Lane Hospital, 1898-1899. A short period of practice in San Francisco was followed by his locating on High Street and later Fruitvale Avenue in Fruitvale, Oakland, where he remained until he moved into downtown Oakland at 20th and Webster Streets about 1917. In 1924 he purchased and developed an office building at 3115 Webster Street, Oakland, California. This building was one of the first physicians buildings to be developed in the hospital district. Here he practiced until his death.

Many professional honors came to Dr. Crosby because of skill and friendly relationship with his fellow physicians. He was one of the early members of the American College of Surgeons in this district. He was Health Officer of Oakland when the influenza epidemic struck in 1918 and it was due to his efforts and organizing ability that the auditorium was converted into a temporary hospital to handle the emergency. Later he became a member of the Alameda County Institutions Commission and for many years did excellent work relative to the various county hospitals and public health projects. Early in his career he became associated with Fabiola Hospital and was very active in its affairs. When California Physicians' Service was first organized he was chosen as its counsellor for Alameda County. He was for a time President of the California Association of Approved Hospitals. Several different years saw him serving as a delegate from Alameda County to the House of Delegates of the California Medical Association. He also had been on the Council of the Alameda County Medical Association and was a Past President of that association. He had long been a member of the California Academy of Medicine.

While in medical college Dr. Crosby joined Phi Gamma Epsilon medical fraternity which later became a chapter of Alpha Kappa Kappa. He was a Mason, having formerly belonged to Fruitvale Lodge No. 336. Other fraternal affiliations included the Athenian Nile Club and the University Club. He was active in the Oakland Forum and was its President from 1933 to 1935.

His well rounded life included a number of nonmedical interests and hobbies. Gardening was one of them and his skill in it was evidenced by the lovely grounds surrounding his Piedmont home and his Webster Street office. He was an active member of the Oakland Business Men's Garden Club. In the last year of his life he was active in the gardening decorations of the Hospitality House for Service Men.

Another of the Doctor's interests was old books, particularly about Ireland. He was in frequent communication with book dealers in Ireland and imported old and rare books of the country of his ancestors.

Gracious, intellectual and spirited conversation with his friends was one of his pleasures. No party was dull when Crosby was there. Anecdotes, stories of his early Portuguese patients, reminiscences—all came quickly to his mind and tongue. He was never at a loss to illustrate a point with a pertinent tale.

H. J. Templeton, M.D.,
John A. Dougherty, M.D.,
Theodore W. Weller, M.D.

CALIFORNIA PHYSICIANS' SERVICE†

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On Repayment of C.M.A. Loan to C.P.S.

When California Physicians' Service was organized it was necessary to provide it with sufficient funds to cover the costs of administration of the organization, and professional and hospitalization care of beneficiary members (patients). Because C.P.S. is the child of the California Medical Association, the latter organization loaned California Physicians' Service the sum of $42,000, of which amount $7,000 was paid last year.

The letter of August 26, 1944, which follows expresses the good wishes of Council Chairman Gilman, sent when the remaining balance due the C.M.A. ($35,000) was recently paid. A reproduction of the check appears on this page.

President-Elect Gilman's letter follows:

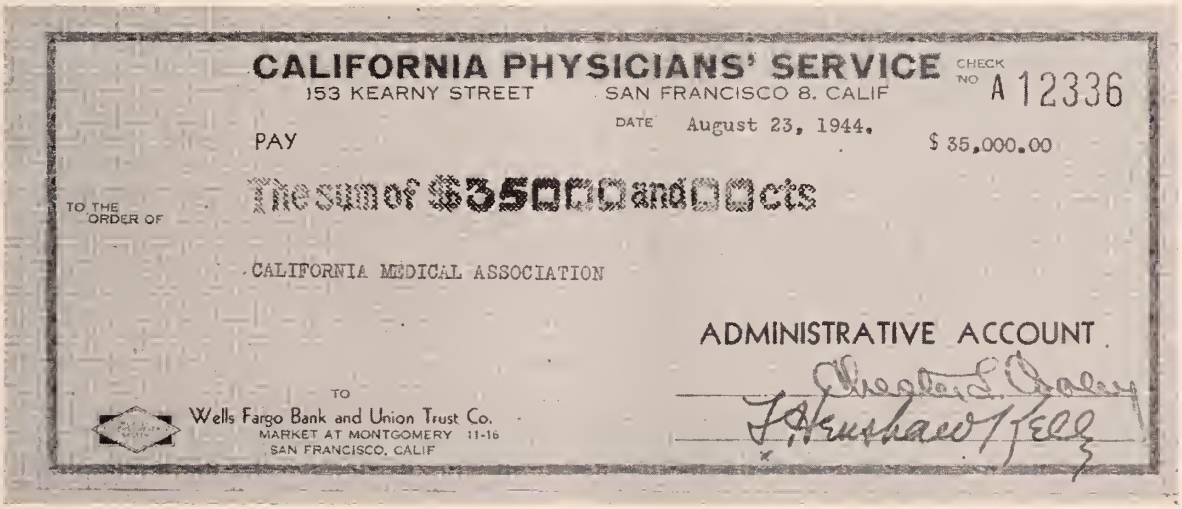
* * *

(COPY)
August 26, 1944.

A. E. Larsen, M.D.,
Executive Medical Director,
California Physicians' Service,
153 Kearny Street,
San Francisco 8, California.

Dear Doctor Larsen:

This will acknowledge with thanks the receipt of your check for $35,000 in complete payment of the note of California Physicians' Service to the California Medical Association. I am sure I voice the thought of the entire Council of the C.M.A., as well as the membership at large, in saying that this repayment marks a tremendous step forward in the affairs of California Physicians' Service and provides a conclusive answer to those who have doubted or questioned the financial stability of California Physicians' Service.



CALIFORNIA PHYSICIANS' SERVICE
153 KEARNY STREET SAN FRANCISCO 8, CALIF
CHECK NO A 12336
DATE August 23, 1944.
PAY $ 35,000.00
The sum of $35000 and 00 cts
TO THE ORDER OF
CALIFORNIA MEDICAL ASSOCIATION
ADMINISTRATIVE ACCOUNT
Chester L. Cooley
T. Henshaw Kelly
TO
Wells Fargo Bank and Union Trust Co.
MARKET AT MONTGOMERY 11-16
SAN FRANCISCO, CALIF

Announcement of the receipt of this check was made at a meeting of our Executive Committee yesterday and that committee voted to consider this sum of money as an item apart from the general association funds until the next meeting of the C.M.A. Council, which will be on October 1, 1944.

Personally, I am particularly gratified that C.P.S. can prove its financial integrity at this time by making such a sizable repayment.

Cordially yours,
PHILIP K. GILMAN, M.D.,
Chairman of the Council.

Repayment of C.M.A. Loan: Informative Letter from Dr. T. Henshaw Kelly, Secretary of Board of Trustees of C.P.S.

The last meeting of the Board of Trustees was held on August 20, 1944, in San Francisco. The highlight of this meeting may be expressed by the following letter:

* * *

P. K. Gilman, M.D.,
Chairman of the Council, California Medical Association,
San Francisco (8), California.

Dear Doctor Gilman:

At its meeting at San Francisco on August 20, 1944, the Trustees of C.P.S. directed that the balance of the loan of $42,000 made by the C.M.A. to initiate the operation of C.P.S. be repaid.

I therefore enclose the check of California Physicians' Service for $35,000, the amount of this balance, and request the return of the note which has secured this loan.

The Trustees expressed their pleasure at the satisfactory financial condition of C.P.S. which permits the repayment of the loan at this time.

Very truly yours,
A. E. LARSEN, M.D.,
Executive Medical Director.

* * *

The repayment of this loan to the C.M.A. prompts the review of the background of C.P.S. as it relates to this particular sum of money.

When C.P.S. was first incorporated, in the early part of 1939, it was obvious that funds would be necessary for organization purposes. The California Medical Association advanced the $42,000 to C.P.S. for this purpose. Long before C.P.S. received any income from enrolled groups, the greater part of this sum had been spent in enlisting the professional members throughout the state, which entailed numerous meetings, with travel and other expenses necessarily a part of this work.

As groups were being enrolled in the latter part of 1939, C.P.S. had practically no reserve to work on and was faced with the necessity of developing a statewide organization with machinery for acquisition of groups and, of course, the necessary salaried personnel to effect this. During the early days of C.P.S., the costs were kept at a minimum, due to the volunteer efforts of such men as E. Vincent Askey, Alson R. Kilgore, T. Henshaw Kelly and Morton R. Gibbons. These men took time out from their busy private practices to spend hours during the day time, and frequently late in the evening, on purely office and clerical jobs. It was only in this manner that C.P.S. was able to hold itself together until sufficient income from the enrollment of groups could support a regular staff. Most of the presonnel that came with C.P.S. on a full or part time basis came at greatly reduced salaries. During the years 1940 and 1941, by reason of the reduced unit value which spread the financial load among several thousand participating physicians, C.P.S. was able gradually to build up a small reserve.

During these years, C.P.S. was laboring with the full coverage contract. This contract was more or less imposed upon C.P.S. by the House of Delegates at the time of its organization. After exposure to some 15,000 to 20,000 people over a period of a year or more, it was recognized to be an offering that would not compensate physicians adequately for their services at the rates that the public was able to pay, and at the rate at which the beneficiaries used the service.

Foreseeing that it would be necessary to take drastic action with respect to this initial offering, the Board of Trustees of C.P.S. saw the necessity of building a reserve fund, looking forward to the day when the existing full coverage contracts could be transferred to others on a sounder actuarial basis. The Board of Trustees also recognized that it must have sufficient actuarial data upon which changes were to be based, since there were no data to which they could turn with confidence. C.P.S. kept elaborate statistics for this purpose.

As material evolved, and upon consultation with a consulting actuary, C.P.S. decided, early in 1942, to withdraw the full coverage contract and to substitute a two visit deductible and surgical contract. The conversion of the existing full coverage contracts was delayed until the latter part of 1942. The conversion of the 20,000 full coverage contracts was approached with the fear that any substantial losses of membership would perhaps cripple the organization and add the threat of putting it out of business. Of course, 1942 was the worst possible time in history to make such a decision, since it was the beginnnig war year, and labor unrest and turnover were completely unpredictable factors in their effect on anything that might be done to hold old groups, and particularly in the enrollment of new groups. However, C.P.S. weathered the storm of 1942, and conversion took place with increasing rapidity and reached its maximum in the middle of 1943.

From then on, with all of the full coverage converted, and with the increasing enrollment of new groups under the surgical and two visit deductible contracts, the affairs of C.P.S. almost immediately took a turn for the better. In only the last ten months, C.P.S. has accumulated the bulk of its reserve fund, amounting to over $100,000, which included the $35,000 C.M.A. loan ($7,000 having been previously repaid). All during this time, the unit value was also steadily increasing, from the low of $1.10 to its current value of $2.25, which is 90 per cent of par.

In considering the repayment—which was not obligatory—the Board of Trustees of C.P.S. felt that C.P.S. could now stand on its own feet financially, and C.P.S. is also appreciative of the efforts that the C.M.A. is making to further the development, present and future, of C.P.S.

It can be pretty safely said today that the medical profession of California has made a sound investment in its C.P.S., the potential of which, from both the social and economic points of view, represents unknown resources which only time can reveal.

T. HENSHAW KELLY, *Secretary.*

Meeting of C.P.S. Trustees

The Board of Trustees of C.P.S. had its regular meeting on Sunday, July 16th. Various progress reports were made.

The expanded acquisition activities continue to produce encouraging results. Almost 10,000 new persons were enrolled during May. This is the largest number enrolled in any single month in C.P.S. history, and as a result, the income from membership dues also reached its highest peak to date.

It is evident that the program of decentralization of acquisition activities has contributed directly to this improvement. It is also evident that the increasing coöperation by professional members is having its effect.

The Medical Director's report also contained some very interesting recommendations. Because of the improved financial position of C.P.S. with respect to both current unit value and the unit stabilization fund, the Medical Director has proposed to the Trustees a plan for stabilizing and accelerating payments to doctors for services rendered. The Trustees have accepted the recommendation and instructed the Medical Director to proceed with the change in mechanics of office procedure to produce this desirable result.

In the past, the unit value for services rendered in a particular month could not be determined until all the reports from all professional members with respect to services rendered in that particular month had been received in our office. Professional members were requested to send in their reports at the end of the month, or at least before the 15th of the month succeeding. The great majority of the reports reached our office about the 15th to the 20th of the succeeding month. From this you can readily see that it has been impossible to complete the work in the office, determine the unit value and issue the checks to the doctors much before the middle of the second succeeding month.

During the formative years of C.P.S., when there were violent fluctuations in the value of the unit from month to month, and when C.P.S. had no stabilization fund in any sizable amount, it was necessary to follow this procedure in order to preserve financial solvency. However, under present financial conditions it is not so necessary, because the unit can be fairly well estimated over a period of several months in advance, and minor miscalculations in this estimate can be compensated for from the unit stabilization fund.

The new proposal, therefore, is in two parts: (a) To set the unit value at $2.25 for a period of two or three months in advance; (b) to accelerate in all ways possible the passage of these reports through the office clerical functions, so that checks may go out to the doctors in the order the reports are received, without holding all work until the whole month's units have been calculated.

The Medical Director's recommendation is based upon the greater stability of the current two visit deductible and surgical contract experience. It is believed that the present form of contracts has been in effect long enough that probable experience within a given month can be estimated during that month. This is done by a system whereby it is possible to estimate costs of services from initial reports in advance of receiving the actual bill. Since income from membership dues and the administrative expenses are known by the end of the month, advance estimated costs can be determined with reasonable accuracy. It is believed that C.P.S. has reached sufficient stability that there should be little variation in the unit value from month to month. The unit stabilization fund should be used to support the unit value in a particular month where service is heavy, and should receive the excess of income in a particular month when the service is light.

The changing of the necessary office activities will start at once. There is now in the office a certain amount of work pertaining to current and previous months, and the complete effects of this change cannot, therefore, be expected immediately. However, this is a definitely progressive move in the operation of C.P.S., and no effort will be spared to accomplish the objective.

T. HENSHAW KELLY, M.D., *Secretary.*

CALIFORNIA PHYSICIANS' SERVICE[†]

Dear Doctor:

One of the most important objectives of California Physicians' Service has been to make prompt payment to the professional member for services rendered.

For several years one of the major problems confronting us has been the slow and laborious processing of claims to determine the monthly unit value before we could issue the checks.

Now that we have attained a sound financial basis of operation, and the stability of the unit value has been established by reason of the excellent qualities incorporated into our two-visit deductible and surgical contracts, we are gratified to announce the accomplishment of a goal we have striven to reach since the inception of *California Physicians' Service, i.e.,*

Acceleration of Payments to the Doctor for Professional Services Rendered

During the next several months we expect to speed up the processing of usual monthly claims to the point of remitting *twice monthly.* Later this procedure will be improved still more and you will receive your checks on a *weekly* basis.

Promptness in forwarding claims to us is essential. *Remember to inform your nurse that the sooner she sends us your bills the faster will be the return.*

Sincerely yours,

A. E. LARSEN, M.D., *Executive Medical Director.*

* * *

CALIFORNIA PHYSICIANS' SERVICE

July 26, 1944.

Dear Doctor:

In addition to the present unit value of $2.25 you may be interested to know that the general financial position of C.P.S. is also in a healthy condition.

Balance Sheet of Trust Funds
March 31, 1944

ASSETS		
Cash	$287,186.00	
Membership Dues in Process of Collection	29,431.00	
Furniture and Equipment and Other Prepayments	18,346.00	
Total		$334.963.00
LIABILITIES		
Apportioned for Medical Services Not Yet Completed	$169,199.00	
Membership Dues Collected in Advance	35,671.00	
Miscellaneous Accounts Payable	34,710.00	
Total		$239,580.00
Unit Stabilization Fund (Including Advance by C.M.A.)		$ 95,383.00

Compiled from the Audited Report of
Lester Herrick & Herrick
Certified Public Accountant
(C.P.S. Members have received over $1,500,000 in Medical Services during the past year)

Hospitals today, despite their crowded conditions, must be ready to care for veterans of the present war and they must consider themselves *an everyday necessity* in the life of the American people.

Almost all men are intelligent; it is method that most of them lack.

[†] Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone, EXbrook 0161. A. E. Larsen, M. D., Secretary.

Much of the "copy" of the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column. (Item appears in most issues.)

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session will be held in New York City.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note. For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a.m., under the title, "Your Doctor and You."

In August, KFAC will present these broadcasts on the following Saturdays: September 2, 9, 16, 23 and 30.

The Saturday broadcasts of KFI are given at 9:45 a.m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Departments of the United States Army and the United States Navy, are on the air each Saturday at 1:30 p.m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians*:

1. *About Books:* Worthy of being bound separately as a book is the May, 1944, issue *of the Journal of Nervous and Mental Disease*, dedicated by his California colleagues to Howard Naffziger on his 60th birthday; from Roy Abbott to Robt. Wartenberg, the 49 articles are excellent, with Frank Hinman's *Euthanasia* especially courageous and philosophical, and K. F. Meyer's analysis of the blood-brain barrier especially informative. Columbia Press, N. Y., publishes F. Schrader's *Mitosis* (1944, $2). B. P. Babkin's *Secretory Mechanism of the Digestive Glands* is a must (Hoeber, N. Y., 1944, $12.75). G. F. Gause's *Optical Activity and Living Matter* appears as No. 2 of B. J. Lujet's items on general physiology (Biodynamica, Normandy, Missouri, $2.75). W. Goldring and H. Chasis offer *Hypertension and Hypertensive Disease* (Commonwealth Fund, N. Y., 1944, $3.50). J. L. T. Appleton revises his *Bacterial Infection in Dental Practice* (Lea & Febiger, Phila., 1944, $7). The F. A. Gibbs issue an *Atlas of Electroencephalography* (Addison, Cambridge, Mass., 1944, $8). C. C. Thomas's stimulating list includes S. L. Osborne and H. J. Holmquest's *Technique of Electrotherapy;* J. A. Reyniers' *Micrurgical and Germ-free Methods*, and F. J. Sladen's *Psychiatry and the War* (Springfield, Ill., 1944, $7.50, $5 and $5). F. R. Lillie properly writes account of *The Woods Hole Marine Biological Laboratory* (Univ. Chicago Press, 1944, $4). Henry Schuman of New York plans to publish T. E. Keys' excellent *History of Anesthesia* appropriately for the approximate centennial.

2. *Antibiotics:* Merck & Co.'s mimeographed brochure (127 pp.) on penicillin is most comprehensive summary to date (303 references). H. J. Robinson's doctoral thesis under S. Waksman at Rutgers should be published for wide distribution (*Toxicological, Bacteriological, and Pharmacological Properties of Antimicrobial Agents Produced by Soil Microörganisms* (New Brunswick, 1943). R. D. Hotchkiss well reviews information on gramacidin, tyrocidin and tyrothrycin (*Advances in Enzymology*, 4:201, 1944). H. J. Robinson and Co. propose streptothricin for infected wounds and burns (*Science*, 99:540, June 30, 1944). V. Bryson & Co. suggest aerosolization of penicillin solutions for treating infections of the respiratory tract (*Science*, 100:33, July 14, 1944).

3. *Cancer:* M. Juhn describes possible diagnostic use of feather germ reaction in brown leghorns to urines from cancer patients (*Arch. Path.*, 37:383, 1944). U. R. Potter offers plausible account of energy transformations in relation to cancer (*Advances in Enzymology*, 4:201, 1944). The M. Silberbergs suggest 3, 4 benzpyrene as possibly useful in wound repair (*Amer. J. Path.*, 20:809, 1944).

4. *Chemotherapy:* H. McIlwain opens series on biochemical characterization of chemotherapeutic action with careful analysis of pantoyltaurine growth inhibition (*Bio-Chem. J.*, 38:20, 1944). T. E. Lowe and H. O. Lancaster

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

admit gentian violet helpful if not specific in treating strongyloidiasis (*Med. J. Austral.*, 1:429, May 13, 1944). D. I. Macht described important detoxifying properties of heparin (*South. Med. J.*, 37:402, 1944).

5. *In Addition:* K. W. Thompson's exhaustive study on relation of dermatomycosis to leg ulcers finally appears (*Yale J. Biol. Med.*, 16:665, 1944). U. S. v. Euler of Stockholm finds nicotine-like acting base in urine which he concludes is piperidine *Nature*, 154:17. July 1, 1944). C. de v. Bevan gives helpful hints for preparation of rickettsiae vaccines (*S. Afr. J. Med. Sci.*, 9:1, 1944). T. C. Hall and H. Lehmann find calcium peptone powder useful for increasing calcium absorption in humans (*Bio-Chem. J.*, 38:117, 1944). A. Hemingway and E. Neil well survey different methods of artificial respiration (*Brit. Med. J.*, 1:833, June 24, 1944). R. Elman concludes that nitrogen balance may be maintained by intravenous protein hydrolysates (*Physiol. Rev.*, 24:372, 1944).

6. *Historical:* Congratulations to the *New Orleans Medical and Surgical Journal* on its centennial. A. A. Moll's *Aesculapius in Latin America* could be muchly improved (Saunders, Phila., 1944, $7). Supplements to *Bull. Hist. Med.* include L. Edelstein's commentary on the Hippocratic Oath and W. Pagel's discussion of the religious and philosophical aspects of Van Helmont's Science and Medicine. M. Shimkin reports on medical education in the Soviet Union (*Amer. Rev. Soc. Med.*, 1:465, 1944).

Santa Barbara County Medical Society to Observe 50 Years of Service.—A half-century of administering to the suffering, repairing the injured, and prolonging the lives of Santa Barbara county residents was passed July 4 by the Santa Barbara County Medical Society, the executive council of which will meet in the near future to decide on appropriate observation of the occasion.

Organized the Fourth of July, 1894, when more than a dozen physicians of the city met for the purpose in the old Union Club room, the society selected Dr. J. B. Shaw as its initial president. Dr. Charles Anderson was named first vice-president; Dr. Z. W. Sanders, of Lompoc, second vice-president; Dr. Robert MacKinley, secretary, and Dr. C. B. Bates, treasurer.

Heading the organization today is Dr. William M. Moffat, who will be succeeded next year by President-elect Dr. G. I. Luton. Vice-presidents-at-large are Dr. Milton Duncan, Lompoc, and Dr. Jules Bertero, Santa Maria. Dr. Alfred B. Wilcox is secretary-treasurer. Council members are Drs. M. J. Geyman, A. E. Koehler, Bertero, Moffat, Irving Wills and Wilcox.

Except for summer months, the membership of 100 physicians and surgeons convenes on the second Monday of each month in Bissell auditorium of the Cottage hospital building. Twenty-five members of the society are on duty with the various branches of armed services throughout the world.

In addition to Dr. Shaw, past presidents include the following doctors in the order in which each served: C. S. Stoddard, William T. Barry, Eugene A. Dial, D. A. Conrad, Benjamin Bakewell, Rexwald Brown, T. A. Stoddard, William H. Flint, Stoddard, William H. Campbell, L. R. Ryan, C. S. Stevens, H. C. Bagby, William J. Mellinger, P. C. Means, Samuel Robinson, Franklin Nuzum, L. W. Hotchkiss, H. E. Henderson, W. D. Sansum, N. H. Brush, Hugh F. Freidell, J. J. Ullmann, H. O. Koefod, M. J. Geyman, Edward L. Markthaler, P. A. Gray, Jr., E. Kost Shelton, Irving Wills, Edward J. Lamb, W. H. Johnston, Henry J. Profant, Harold R. Schwalenberg, and H. L. Schurmeir.

California Industrial Accident Commission: Interim Subcommittee Inquiry.—Sweeping changes in the present procedure and practices of the State Industrial Accident Commission may result from the three day hearing recently held by an Assembly subcommittee on governmental efficiency and economy.

Already, the commission has announced changes in the past procedure. The so-called "secret" file, or memorandum of the hearing referee's findings on compensation cases has been abolished and all documents hereafter will be public, Chairman Paul Scharrenberg announced.

The custom of issuing "directives" tantamount to law also has been tossed into the discard at the commission's orders. . . .

Charles J. Janigan, attorney for the State AFL, has submitted a long list of changes he hopes will be made in the present act. He asked that the rules of practice governing compensation cases be simplified, that at least two full time physicians be employed by the medical department of the commission, that the "panel" of impartial medical examiners no longer be a "secret" one, that red tape now surrounding the filing of claims by injured workers be eliminated and that more liberality be shown to claimants. . . .

An entirely revamped act governing the Commission has been proposed by a group of referees who are dissatisfied with present conditions. . . .

The Assembly committee was created at the special session of the Legislature early this year. The present inquiry was requested by Governor Warren.

Scharrenberg is the sole Governor Warren appointee on the commission. J. C. Garrison and Alexander Watchman were Governor Olson appointees. However, most of the practices complained of have grown up over the years and have not been changed materially until the last few weeks.

Correction.—In California and Western Medicine for June, on page 342, appeared the notice of the death of Lieutenant (j.g.) Edward Draper Curtin. Through error it was stated that the late Doctor Curtin was a graduate of the Stanford University School of Medicine, 1941.

Doctor Curtin graduated from the School of Medicine of the College of Medical Evangelists in that year. Lieutenant Curtin was given a posthumous award of the Purple Heart in recognition of his military service.

Atabrine as a Quinine Substitute.—According to recent articles, it should be possible to eliminate malaria from every civilized country after the war by means of the synthetic quinine substitute, quinacrine (atabrine), and by experience gained in treating the armed forces. An official report states that quinacrine "has proved to have all the antimalarial properties ascribed to quinine" and that large scale production of quinine "is not now considered a matter of importance" for treating army and navy personnel.

The report was made by Research Council's board for the coördination of malarial studies.

The report said military use of quinacrine has shown that it effectively suppresses malaria during and after exposure to infected mosquitoes, without danger to the individual. Experience in the last two years "demonstrated conclusively" that even in acute malarial attacks, quinacrine is as "fully as effective" as quinine and is safer, it said.

New Hospital Planned for Sacramento.—Construction of a new $1,500,000 hospital center at 50th and F

Streets by Sutter Hospital is to be started as soon as materials are available, adjoining the present Sutter Maternity Hospital, the trustees recently announced. Charles F. Dean, architect, already has completed part of the blueprints. Because the General Hospital at 28th and L Streets cannot be enlarged, it is planned to sell this building, possibly for use as a medical arts office building and transfer the equipment to the new site, where the hospital owns 25 acres of land.

More hospital beds are needed because of increased population of Sacramento and surrounding territory, according to R. D. Brisbane, hospital manager. Many patients were turned away last winter for lack of room.

The new hospital will contain 400 beds, compared to 250 available at the present general hospital. The Maternity Hospital has 75 beds.

Preliminary plans call for a two-story reinforced concrete insulated structure to harmonize with the maternity building. Private rooms, with lavatory in each, will replace the out-moded multi-bed ward, with generous use of plastics and insulating glass.

A complete wing will be set aside for children, with a separate air conditioned cubicle for each child, and the latest technical and scientific apparatus. An entire second floor, with 75 beds, will be outfitted for orthopedic cases, which have greatly increased, due to industrial and traffic accidents.

There will be a motel and garage service for relatives who wish to visit patients; library, lounge and restrooms for physicians who must stay near their patients; an auditorium for doctors' and nurses' meetings; landing field for physicians who will use air transportation from valley points, and an interdenominational chapel for religious use, with altars consecrated to different churches.

Tropical Medicine.—The Health Ministry of Mexico is taking steps to establish jointly with Tulane University, New Orleans, a school of tropical medicine near the port of Vera Cruz, officials of the Ministry recently disclosed.

Porter Clinic Is Approved for Residents in Psychiatry.—Langley Porter Clinic on the San Francisco campus of the University of California has been approved as a training institution for residents in psychiatry, according to word recently received.

Approval has been granted by the Council on Medical Education and Hospitals of the American Medical Association, and the American Board of Psychiatry and Neurology concurs, it was disclosed by Dr. Karl M. Bowman, professor of psychiatry in the Medical School of the University of California, and director of Langley Porter Clinic. Formal recognition of a new hospital as a training center for psychiatrists is given only after it has been in operation for one year and has met certain standards set by the A.M.A.

Grass Valley's $700,000 Postwar Hospital.—After the war the dream of Dr. Carl P. Jones, for more than 40 years physician in Grass Valley, may be a dream come true. The new $700,000 Grass Valley (Nevada County) Memorial Hospital in honor of his father, the late Dr. William C. Jones. The elder Jones left his native Tennessee in the gold rush days. In a log cabin in Moore's Flat, Nevada County, he studied medicine after the day's mining. Soon he decided to leave the gold fields to become a doctor.

Cooper Medical School had just started and he was in the first class of what today is Stanford University Medical School. After a period of graduate work in New York, he returned to the Sierra to become chief staff surgeon for Central Pacific railroad then being pushed across the mountains.

He was stationed first at Cisco, then Truckee. With completion of the rail line he returned to private practice and chose Grass Valley as his home.

It was here that Dr. Carl Jones and his brothers, William, Jr., John and George were born. All became doctors with the exception of George, who studied law. The brothers established a hospital, the first equipped to handle surgical cases in northern California. Carl carried on alone after the deaths of his brothers. . . .

One of the many friends Dr. Jones won was Errol MacBoyle, mining engineer and owner of Idaho-Maryland Mine, the biggest gold producer in the West. So great was MacBoyle's admiration for Dr. Jones' work among miners, he decided to assist the doctor in realizing a life's dream—that of having a modernly equipped hospital for the Grass Valley country.

The building site selected, on which much construction has been completed, is set on a high hill overlooking the pineclad countryside. It waits only for some materials which will be released when the war is over. Situated on a knoll at an elevation of 2,800 feet in the middle of a 200-acre apple orchard, the structure is a real departure from the conventional hospital.

Constructed entirely of steel and glass, it is designed with spread wings and individual sun porches. The initial capacity will be 284 beds with rooms large enough to accommodate two beds if necessary.

Equipment purchased in Vienna and Hamburg before the war besides thousands of dollars of additional supplies from American firms will soon be installed and the life ambition of a pioneer doctor will come true.

New Cut Seen in Newsprint.—Further restrictions in newsprint allocations were in prospect on August 10, as the War Production Board (WPB) disclosed that paper supplies for small and special types of newspapers, including labor, fraternal, literary and other publications, will be curtailed beginning October 1.

"March of Dimes" Campaign for War on Infantile Paralysis.—The American people in the "March of Dimes" campaign this year donated an all-time record sum of $10,973,491 to aid in the war against infantile paralysis.

Basil O'Connor, president of the National Foundation for Infantile Paralysis, announced these donations will permit an expansion of the campaign against the disease.

With epidemics or serious outbreaks now taking their toll in 12 States, Mr. O'Connor pointed out that the number of cases reported is already higher than for the comparable period last year when the country suffered its third worst epidemic.

Mr. O'Connor said the national foundation now will be able to add more epidemic fighters and additional equipment for emergency aid and, at the same time, continue its relentless fight to learn how to prevent and cure the disease.

Silicosis Death Payment Voided.—Payment of $1,631.94 by the Industrial Accident Commission to Joanne Rubattino, minor daughter of Guiseppe Rubattino, following his death from silicosis in 1943, was annuled recently by the Third District Court of Appeal.

The court ruled the Commission had erred in apportioning silicosis death benefits over an entire period of employment and ordered it to take further proceedings.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Early Demobilization of Medical Faculty Members Further Education For Discharged Medical Officers, Improved Curriculums Needed

Improvement of curriculums in medical schools to prepare the student more adequately for the problems of today, the early release from the armed forces during the period of demobilization of physicians on medical school faculties so as to restore the quality of medical instruction to a higher level as soon as possible, and the provision of further education for discharged medical officers are the chief challenges facing medical education at the present time.

"The medical schools and their faculties have met the challenge of wartime conditions creditably, teaching more students in less time than formerly in the face of greatly depleted numbers of instructors. . . .

"The studies carried out by the Committee on Postwar Medical Service . . . indicate the magnitude of the problem of providing further education for discharged medical officers . . .

"Numerous problems in undergraduate medical education also must be met." . . .—*J.A.M.A.*, August 19.

Press Visit S. F. Hospital: Sees Stanford's Part in War

Anonymity characterizes much of the research that goes on within the walls of the nation's research institutions. That holds true for the men in white lab coats, staff members of the Stanford Medical School, who spend endless hours in the laboratories and in the classrooms of the Stanford Hospital in San Francisco.

After watching them at work, one is not at all surprised to hear Dr. Loren R. ("Yank") Chandler, '20, dean of the School, remark that "all that is being accomplished is the result of teamwork." . . .

There is no mistaking that the contribution of the Stanford doctors in San Francisco toward the war effort has been as great as that made by the Stanford engineers, physicists, economists, and others.

All this was made apparent to newspapermen, representatives of the Office of War Information, and others last month when they visited the Stanford Medical School under the auspices of the University. . . .

Young doctors today receive deferments for nine months' internship instead of for eighteen or twenty months as in peacetimes. One-third of these are given another deferment of nine months as junior residents, and one-half of this group are given an additional deferment of nine months as senior residents. . . .

Next year, the Army has asked for 27 per cent of the Medical School vacancies at Stanford, while the Navy has indicated it wants 25 per cent. Meanwhile, the University has greatly reduced the minimum requirements of its undergraduates for admission to the Medical School to the basic science studies.

The postwar program of the School has not been completely subordinated by Stanford's part in the war effort. It will call for a complete restoration of the residences as well as fellowships for those men whose educations were interrupted by the war. . . .

Although approximately 50 per cent of the prewar research has been stopped, Stanford's Medical School staff expects there will be little difficulty in continuing when the opportunity arises. In the meantime, Stanford feels a real satisfaction in its participation in the war program, especially where its contributions have greatly advanced the frontiers of science.—Stanford University *Illustrated Review*, June.

Building Program of University of California

A postwar construction program totaling more than $27,500,000 on the eight campuses of the University of California was disclosed yesterday by James H. Corley, University comptroller. . . .

Initial construction planned for the San Francisco campus is a 500-bed Teaching Hospital, for which a $2,000,000 legislative appropriation already is available.

Also appropriated and available as soon as construction becomes possible is a $90,000 laundry and a $135,000 generator plant. A million dollar Medical Science Building, including a medical library and museum of pathology.

This building is planned to replace present outdated and inadequate buildings in accordance with developing a full curriculum in the San Francisco Medical School, each department of which must be provided with classrooms, student laboratories, research laboratories and departmental offices. Interns' quarters, costing $200,000 are planned, and a $500,000 nurses' home is needed.—San Francisco *Examiner*, August 21.

Trained Workers for Mentally Deficient Patients Needed

Common sense compels agreement with the recent conclusion expressed by Mrs. Dora Shaw Heffner, director of state institutions, when she said California should provide training for men and women to be employed in the mental hospitals and homes for the mentally deficient.

California's record in the care of its mentally ill is not good. It ranks 32nd among the States in ratio of patients to employees, 36th in ratio of doctors to patients, 37th in ratio of occupational therapists per patient and 44th, almost at the bottom, in ration of psychiatric nurses per patient.

Furthermore the personnel of employees in the institutions is not uniformly or highly trained for the work. There is pressing need, Mrs. Heffner points out, for addition of many trained workers in all departments of these hospitals and homes.

The new approach to care of the insane is based upon the theory that patients can be cured and returned to normal life, thereby relieving the state of their care. The old idea was to keep them in the institutions until death.

California desperately needs to get in stride with the new concepts. That will require considerable grading up of the employed personnel of the institutions and the state should provide the training to accomplish it.—San Francisco *News*, August 9.

U. S. Surgeon Lauds California's Health Laws

Col. Udo Wile, of the University of Michigan Medical School, and senior surgeon of the United States Department of Public Health, on August 22nd, paid tribute to the Public Health Department of California and urged nation-wide extension of present venereal disease control throughout the postwar period.

"At present we have three agencies working for the control of venereal diseases: the Army, the Navy and the State Departments of Health, assisted by the U. S. Public Health Service. In the period of demobilization, the responsibility will rest almost entirely with the state and city health departments.

"This period will be more critical than the war period because the demobilization of industry will return many persons to scattered, small communities, increasing the possibility of the spread of disease," Dr. Wile said.

Efforts should now be made to insure continuance of adequate venereal disease control through financial help and through public interest and support, according to Dr. Wile.

"We have had for some time various excellent means of case finding, namely annual phyiscal examinations required by many large industries and pre-marital laws existing in some 30 States," the medical director continued.

"After marriage the danger of contracting venereal disease is considerably lessened," he added.

The Rapid Treatment Centers, of which Dr. Wile is the chief consultant situated throughout the country, have been established by the requests of States and with the approval and financing of the Federal Government. Similar treatment centers are needed in every large city, Dr. Wile believes.

Methods used in these centers insure control of the spread of infection within a few weeks. Patients are treated and kept at the hospitals until such time that they are considered no longer infectious. Case finding is facilitated by various contact sources, the courts, the police and other local agencies.

When an infected person is found efforts are made to reach the source of infection. However, Dr. Wile stressed the fact that his department is concerned only with the medical phase of venereal control. Case finding and education are the duty of other organizations.

"The public can be further educated with profit," he said.

His central theme is that with the cessation of hostilities the problem of venereal control will become increasingly important among civilian agencies. The military is adequately handling the problem today among its own and can assure that no service man will be released to civilian life without full examination and, if necessary, treatment. After that it is up to the public.—San Francisco *Chronicle*, August 23.

Tax Reductions Continued for Hospital Charity Groups

Los Angeles, July 5.—(CNS.)—The County Board of Supervisors voted today to continue for another year, a 50 per cent tax reduction on land on which charitable organizations' properties are built, provided they can show no important improvement of financial condition during the past year.

Hospitals in particular, at a time when they are reported enjoying unprecedented prosperity, will be required to show cause why they should receive reductions. —Long Beach *Sun*, July 6.

New Mothers Allowed to Leave Beds Sooner

Chicago.—(TP.)—Old Man Stork has been working overtime lately and although his passengers always are welcomed at the nation's hospitals, there is not always room for the expectant guests.

The report of one doctor, of Baltimore, who set out to do something about the problem, has been recently reported. The doctor rounded up 150 new mothers and allowed them to be up and around Baltimore's Sinai hospital on the third or fourth day after delivery instead of the usual 10 or 12 days spent in bed. He explained that no patient with complications of pregnancy were in the group and that the type of delivery was taken into consideration.

No ill effects were reported and the patients felt well and more able to care for themselves and their infants at home after the sixth to eighth day.

By this means the acute bed shortage in the maternity ward at Sinai hospital was relieved and the welcome sign was able to be put out for new mothers and their coming blessed events.—Long Beach *Independent*, August 4.

'Public Medicine' Urged By Dr. Logan Clendenning In Talk at Santa Barbara

A boost for socialized medicine, which he said should be termed "public medicine," was given by Dr. Logan Clendenning, nationally famous columnist on medical subjects, on July 19, at the weekly meeting of the Kiwanis Club in the Hotel Lobero, in Santa Barbara.

Dr. Clendenning said that "a tragic condition" exists today because so many people who need medical attention cannot afford it and declared that members of the medical profession are giving evidence of being "utterly backward" in their attempts to forestall the movement of socialized medicine.

He said he was in agreement with a pending bill before congress to provide public medical attention to everyone on a nominal, pay-as-you-go plan. Insisting that such a program would raise standards of medical care, the noted medical authority said that "it would provide doctors in general with greater and more secure incomes. But they are the ones who are fighting something they would be better off with." . . .

In conclusion, Dr. Clendenning made a plea for "all of us, as we go into the new world, to discard our prejudices of the past. We will need to face the new generation with new minds, for if we do not, the younger generation is going to, whether we like it or not."—Santa Barbara *News-Press*, July 21.

Medicine

Last month the newspapers headlined the story that the California Medical Association had demanded the ouster of Olin West, secretary, and Morris Fishbein, editor of *The Journal of the American Medical Association.*

Contrary to widespread belief, the resolutions proposed by the California delegates to the A.M.A. convention were far from progressive. They did not attack the reactionary character of the West and Fishbein leadership, but only what they termed its "unnecessary continuous defensive attitude." . . .

The California Medical Association also urged more vigorous A.M.A. lobbying against progressive medical legislation as well as the passage of the Miller bill to destroy the maternity and infant-care program for servicemen's families.

The A.M.A. House of Delegates turned down the California resolutions on West and Fishbein, in the interest of unity against the demands of the people for better medical care through the Wagner-Murray-Dingell bill.

For liberal words and reactionary deeds, the A.M.A. meeting was almost as bad as the Republican convention.

The A.M.A. resolved that "the unionization of employees in hospitals might jeopardize the health, safety and lives of patients," and declared its strong opposition to such activities.

This anti-labor declaration is all the more ironical since the A.M.A. has been saying for many years that all the workers need in order to get better medical care is to receive higher wages. Morris Fishbein and Olin West even posed as champions of social reform. Yet everyone knows that hospital workers receive probably the lowest wages of any group of workers. . . .—Celia Langer in San Francisco *People's World*, August 1.

Political Action Committee on Free Radio Time

I have just come into possession of a very instructive booklet put out by the Political Action Committee of the C.I.O. It tells P.A.C. members how to obtain free time on the radio.

The book begins by informing members that radio stations belong to broadcasting companies—which may be news to the broadcasting companies for all I know. But —it adds—the air belongs to the people.

Personally, I think the latter statement is pretty far-fetched. . . . However, the booklet continues:

"We, the people, have the exclusive right to the air, and we, through our elected Government, can grant the privilege to broadcasters to use our air, for as long as they serve us well."

The tome then goes on to tell P.A.C. members that they can demand free time on the radio and make it stick. It adds:

"It is quite possible that some radio manager will refuse to give you free time and will refuse to sell you time. If that hapens, here is what to do:

"You ask the station manager to give you his refusal and his reason for refusing in writing.

"Copy that letter and attach it to your explanations why you think his refusal is unfair.

"Send copies of his and your letter to: James Lawrence Fly, chairman, Federal Communications Commission, Washington, D. C.

"Send copies to the C.I.O. Political Action Committee for our attention and action.

"Let the station manager know how widely you are distributing your protest of his unfair treatment. Let your local newspaper know about it.

"If there are other radio stations in your community, approach them for time while your protest is publicized."

This worthy advice is followed by this significant statement:

"If enough union leaders ask for time on the radio and protest vigorously enough when they are denied, there would soon be no need for protesting."—George Dixon in San Francisco *Examiner.*

U. S. Court Withdraws Decision Invalidating Food Patent of Wisconsin Alumni Research Foundation

The United States Circuit Court of Appeals in San Francisco, on August 23, took the unusual action of withdrawing its opinion on June 30, 1943, which invalidated valuable patents held by the Wisconsin Alumni Research Foundation for preventing and curing rickets through food treated with ultra-violet rays.

The court gave no explanation of its action, simply announcing it had withdrawn the opinion.

The university, which said the so-called "Steenbock patents" had netted it $7,500,00 in royalties from some 250 licensed companies, had petitioned for a rehearing, and its action still is pending.

Gist of the court's June opinion was that a process utilizing sunlight could not be patented since solar energy is available to all mankind, and that the Steenbock patents were invaluable discoveries but not inventions.— San Francisco *Examiner,* August 24.

Too Much Sickness Insurance, Not Enough Health Insurance

The terms "sickness insurance" and "health insurance" connote two quite different things. Sickness insurance concerns itself with facilitating the recovery of people from sickness, once it has overtaken them. Health insurance concerns itself with minimizing the hazards that are likely to make them sick. On the theory that the more effective health insurance is made, the less will be the costs for sickness insurance, it would seem only logical that Canada should be planning to spend more and more on preventive measures that will be permanent in their beneficial effect, so that she may look forward to having to spend less and less on medical services that merely put a temporary stop to troubles that need not have happened.—From *Health Insurance for Canada* by Research Bureau, Canadian Pharmaceutical Manufacturers' Association.

Dr. John D. Rudlock Assigned to Naval Hospital

Appointment of Captain John C. Ruddock, former president of the Los Angeles City Health Commission and the Los Angeles County Medical Association, as chief of medicine at the U. S. Naval Hospital in San Diego was announced on August 10.

Dr. Ruddock, who is 53, had been in the Navy's medical reserve for many years.—Los Angeles *Examiner,* August 11.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

California Workmen's Compensation Act As It Affects Physicians and Surgeons

This is the first of a series of articles on the status of California physicians and surgeons under the State Workmen's Compensation Act, with particular attention directed to the fees paid physicians and surgeons in industrial injury cases and the functions of the Industrial Accident Commission in connection therewith. Articles on this subject will be contained in this column in succeeding issues.

The Workmen's Compensation Act is now contained in the *California Labor Code.* Under the provisions of *Labor Code,* Sec. 4600, a duty is imposed upon all employers in cases of industrial injuries to provide the injured employee with such medical, surgical, and hospital treatment as is reasonably required to cure or relieve from the effects of the injury. The employee is entitled to receive all medical treatment which reasonably is necessary to restore him to a physical condition permitting the resumption of the duties of his employment. In the first instance, the employer has the right to select the physician; but if an employee so requests, the employer must tender him one change of physicians, nominating for this purpose at least three additional practicing physicians from which the employee may choose.

To protect the physician and surgeon rendering services in Workmen's Compensation cases, *Labor Code,* Sec. 4903 provides that the Industrial Accident Commission may determine, and allow as a lien against any amount awarded to the injured employee by way of compensation, the reasonable value of medical and hospital services rendered. Also the Industrial Accident Commission is vested with jurisdiction over any controversy relating to, or arising out of, the provisions of the Workmen's Compensation Act with respect to medical care, unless an express agreement fixing the amount to be paid for medical, surgical, or hospital treatment has been made between the parties or institutions rendering such treatment and the employer or his insurer. Section 4604 of the *Labor Code* provides that controversies between employer and employee arising over medical and hospital treatment shall be determined by the Industrial Accident Commission upon the request of either party. It was held in *Independence Indemnity Company vs. Commissioner,* 2 Cal. (2d) 397, that the Industrial Accident Commission has jurisdiction to hear a proceeding originally commenced by a physician to recover the reasonable value of his services if the injured employee is made a party to the proceeding. In such proceeding, or in any proceeding, before the Industrial Accident Commission either commenced by employee, employer, or physician, the Commission has express authority under *Labor Code,* Sec. 4907 to determine what constitutes a reasonable amount for medical and hospital expenses in any specific case.

Having full power and jurisdiction to determine the reasonable value of medical or surgical services in industrial accident cases, the Industrial Accident Commission, in 1913, when the Workmen's Compensation Insurance and Safety Act was first enacted, adopted a fee schedule to provide a standard or guide for determining the reasonable value of medical and surgical services rendered for those cases which might be brought before the Commission. The fee schedule adopted in 1913 by the Commission was revised to a small extent in 1920, but no further action was taken by the Commission until September, 1941, when the fee schedule, as originally adopted in 1913 and amended in 1920, was readopted. Therefore, the existing fee schedule under which awards are being made currently to physicians and surgeons in the State for services rendered in industrial accident cases, has been in existence unchanged for 24 years, with a number of the items remaining unchanged for 31 years, with the exception of the temporary surcharge order (limited to the Duration) which we will deal with in a succeeding article.

The existing fee schedule states that it shall be considered and treated as a minimum schedule; but in practice it is used as a statement of maximum fees in all awards made by the Industrial Accident Commission, and likewise it is used as a guide for maximum fees by private employers and their insurance carriers in compensating physicians employed by them to render services to injured employees.

The California Medical Association is presently engaged in an effort to procure the adoption by the Industrial Accident Commission of an entirely new fee schedule which will afford physicians and surgeons reasonable and adequate compensation for their services in cases of industrial injury.

Deaths on the battlefield are not the chief costs of war. Battle deaths comprise only 1 per cent of the armed forces per annum. Armies include about 10 per cent of the population of warring countries. Disease rates are about one per cent per annum. Thus diseases kill ten times more than battles, even in countries at war. Civilian mortality and morbidity are of military importance. The sanitary facilities that protect our population from the diseases that spread through inadequate water, sewage and food hygiene must be maintained and extended. The spread of tuberculosis and other infectious diseases should be prevented wherever practicable. . . . These are all important war measures that should rank with military preparations in our national policy.—Lt. Comdr. Emil Bogen, MC, U. S. N. R., *Amer. Rev. of Tbc.,* March, 1944.

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† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVII, No. 9, September, 1919

EXCERPTS FROM EDITORIAL NOTES

Locations for Doctors.—The physicians of California who have been in service are rapidly returning to their homes. Many of them are seeking new locations. A general shaking-up of locations is in progress. There are many opportunities for practice in the smaller towns and rural sections, especially, and there are many places where physicians are urgently needed. It is requested that every person knowing of any such need or opportunity for practice will communicate with the office of the State Medical Society, as this office is in a position to place many doctors throughout the State if only local needs can be recognized. It is a matter of service to these communities, and also of service to the returning physicians who wish to lose no time in reëstablishing themselves. It is the desire of this office to serve both. Will you assist? . . .

The Boy Scouts' Oath.—The Boy Scout promises on his honor

"1. To do my duty to God and my country, and to obey the Scout Law,

2. To help other people at all times,

3. To keep myself physically strong, mentally awake, and morally straight."

How is that for a program for the average busy physician? This latter has all too little time to consider questions of morals and ethics. . . .

Lines of Effective Preventive Medicine.—According to the summary of mortality statistics for 1917 by the Census Bureau, twenty-seven states, forty-three cities additional, and the District of Columbia, containing all told, 73 per cent of the population of the United States, now comprise the registration area of the United States. Over a third of the recorded deaths in this area were due to cardio-renal disease, apoplexy, cancer, enteritis, influenza, diabetes, diphtheria and bronchitis. Here is a group of diseases on which preventive medicine should concentrate. Epidemic diseases with known or unknown bacterial causes are rapidly being rendered controllable. . .

Medical Examinations.—Few graduates of medical schools have failed to comment at some time on the imperfect coaptation of medical examinations to the problem of determining if a certain student has learned enough to make a safe and fairly efficient doctor. The same problem arises in the examinations of state medical examining boards. How shall it be determined that a certain applicant can be released upon the public with assurance of safety to the public and benefit to the sick? We are not now concerned with the further problem, equally crucial, as to how it shall be determined whether representatives of various faddist and short-cut methods are safe to be entrusted with the function of healing

(Continued in Front Advertising Section, on Page 20)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M.D.
Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held at the Elks Club, Los Angeles, from August 21st to 24th, inclusive.

Applicants for written examination included Physicians and Surgeons, Chiropodists and one Midwife.

An oral examination was held at the Board office in Los Angeles on August 19th, such examinations being required of applicants basing their application to California on a license issued more than ten years ago by their home state.

Legal hearings were held, pursuant to the issuance of citations, and complaints charging infractions of various sections of the Business and Professions Code.

News

"Charges that Dr. M. M. Kirksey, physician and surgeon at the Stockton State Hospital, was abusive to patients and fellow employees, were filed with the State Personnel Board today by Dr. Margaret H. Smyth, hospital superintendent, who asked for Dr. Kirksey's dismissal from State service. On June 7, Dr. Smyth charged, Dr. Kirksey lifted patient Lew Fay by the hair and hurled him several feet. The complaint accuses Dr. Kirksey, who has been on the hospital staff since June of 1936, of making physical attacks upon George Schlein, Emil Berke and Joe Vaughn, hospital employees." (Associated Press dispatch, dated Sacramento, Aug. 3, from San Francisco *Call-Bulletin*, Aug. 3, 1944.)

"A restraining suit brought by 20 chiropractors of the Los Angeles area in the Sacramento county superior court yesterday charged that the State Board of Chiropractic Examiners had 'interfered' with their operations. The action, brought by attorney Morris Lavine, alleged the Board acted arbitrarily and without a hearing to revoke the plaintiffs' licenses. Judge Peter Shields will decide August 7 whether to issue a permanent restraining order." (Los Angeles *Daily News*, July 15, 1944.)

"In an unheralded appearance in Superior Court yesterday, Dr. Roland W. Harris, chiropractor, charged with the murder of Mrs. Julia Zubillaga, 26-year-old mother of five children, walked into the courtroom of Judge Leslie E. Still with his attorneys, Walhfred Jacobson and Henry Rupp, and asked the court for permission to withdraw his plea of not guilty to the murder charge and to enter a plea of guilty to a charge of manslaughter. Judge Still granted the permission and ordered Harris arraigned on the charge of manslaughter. . . . Manslaughter is a probational offense in California, and on his plea of guilty the chiropractor may be granted straight probation without imprisonment or he may be granted probation with the condition that he spend some time in the county jail. If the probation in any form is granted, the chiropractor will escape the penitentiary, but if probation is denied he will be sentenced to the State prison from 1 to 10 years." (Long Beach *Sun*, July 14, 1944.)

(Continued in Back Advertising Section, on Page 50)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.
Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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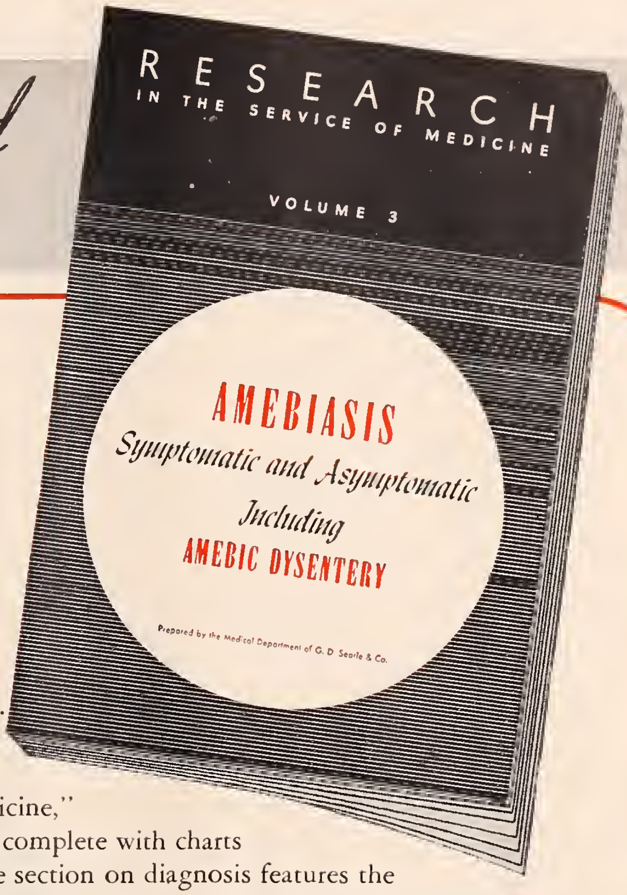
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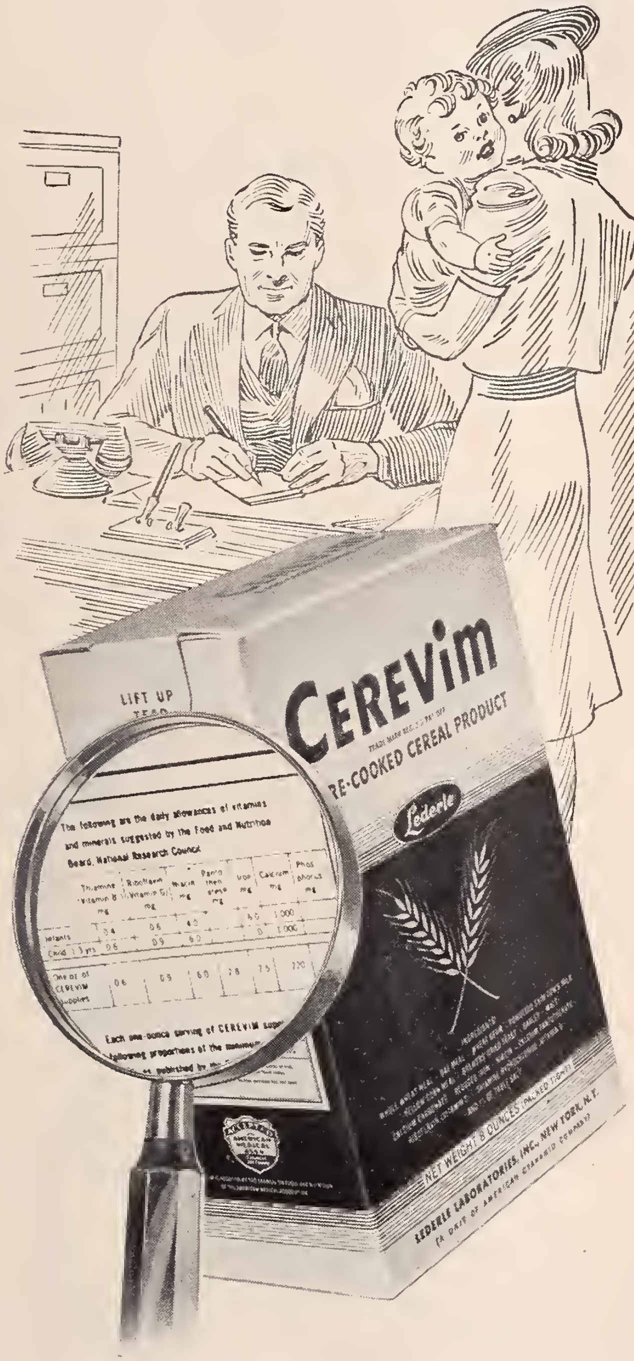
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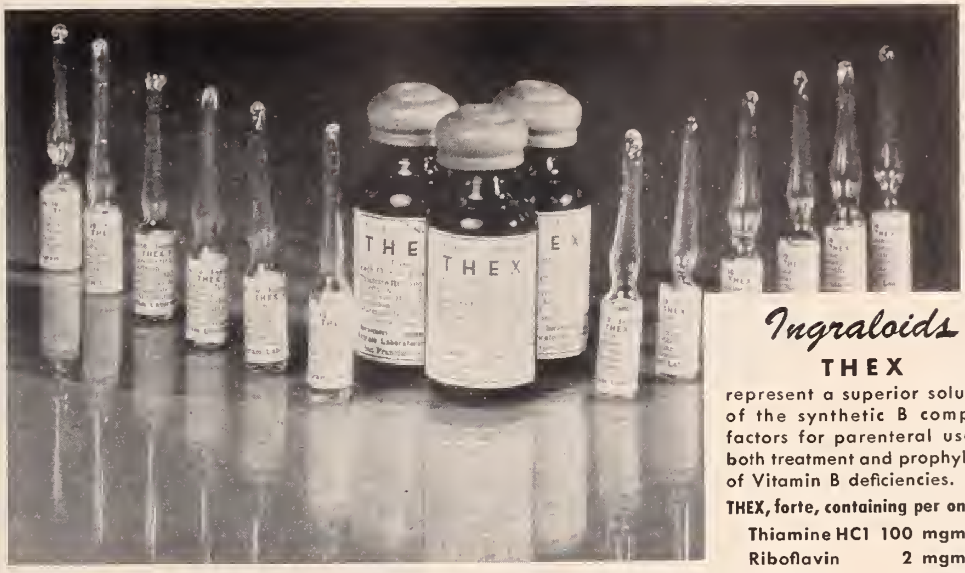

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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

body and the effect does not become apparent until this accumulation has reached a certain point. Among the means that have been suggested for overcoming this difficulty are injections of digitalis preparations either subcutaneously, intramuscularly, or intravenously. Subcutaneous and intramuscular injections are usually painful, while intravenous injections are less easily given and are attended with some increased danger. In any case full doses must be given in order to attain a prompt therapeutic result. For these reasons the introduction of a method whereby digitalization can be accomplished rapidly and with comparative safety, by oral administration of the drug, is a welcome addition to the modes of giving this drug. . . .

From an Article on "A Schematic Method for Estimating the Health Status of the Runabout Child," by C. Edgerton Carter, M.D., Los Angeles.—This is the time of a new viewpoint,—a renaissance due at first to the stimulus of the World War and now to the dawn of an appreciation of the possibilities that are ours in Conservation. Conservation of wealth, of life, of health, or in whatever direction we bend our efforts, astonishes us in its cumulative result. A life saved carries with it its capacity for achievement. . . .

From an Article on "Economical Aspects of State Hospital Discharges and Paroles," by M. J. Rowe, M.D., Mendocino State Hospital, Talmage, Cal.—During the two years ending June 30, 1918, there were 1,472 patients under treatment as insane. Of this number some have

(Continued on Page 36)

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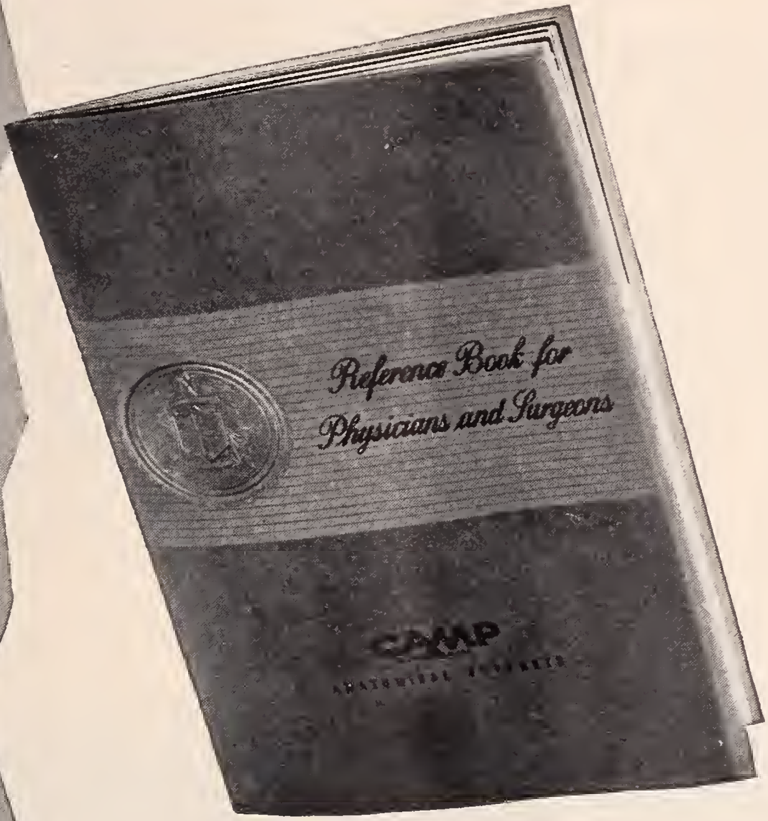

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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

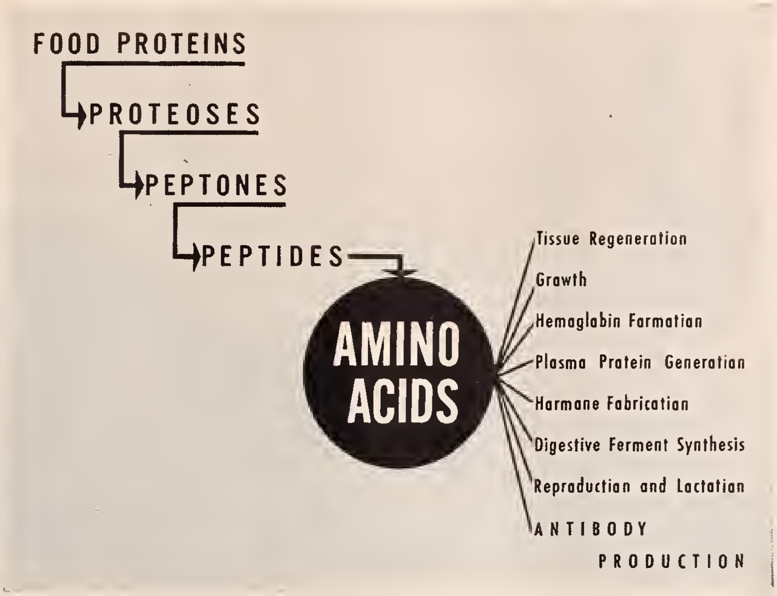
been residents since the opening of the hospital in 1893, while 379 were admitted during the last two years. Their ages are between 10 and 93 years.

From among this number 182 patients left the hospital to renew their social relations independently or with the assistance of relatives or friends. Their relationship to the hospital at the time of leaving is shown in Table I. . . .

From an Article on "The Use of Camphor as a Stimulant and as a Pneumococcicide in Pneumonia," by F. F. Gundrum, M.D., Sacramento, Cal.—The hypodermatic use of camphor dissolved in oil as a stimulant is too widespread to require introduction. All drug stores carry a supply of this drug in ampoules sterilized and ready for immediate exhibition. The injection of camphor in larger doses with expectation of producing a pneumococcicidal effect has not been so universally adopted, but has been urged by Seibert and Cruikshank who report excellent results from this procedure. . . .

From an Article on "Focal Infections and Nerve Reflexes as Related to the Eye," by Clarence Edward Ide, M.D., San Diego.—My reason for selecting this subject is that in the course of my work I spend considerable valuable time arguing with dentists and fellow physicians in the effort to convince them that pathological conditions in the eye many times have their real, original cause, or source, in diseased areas in the teeth especially, or the tonsils, sinuses, ears, parotid glands, or just as

(Continued on Page 40)


FOOD PROTEINS
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PEPTONES
PEPTIDES
AMINO ACIDS
Tissue Regeneration
Growth
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Digestive Ferment Synthesis
Reproduction and Lactation
ANTIBODY PRODUCTION

Resistance to Infection

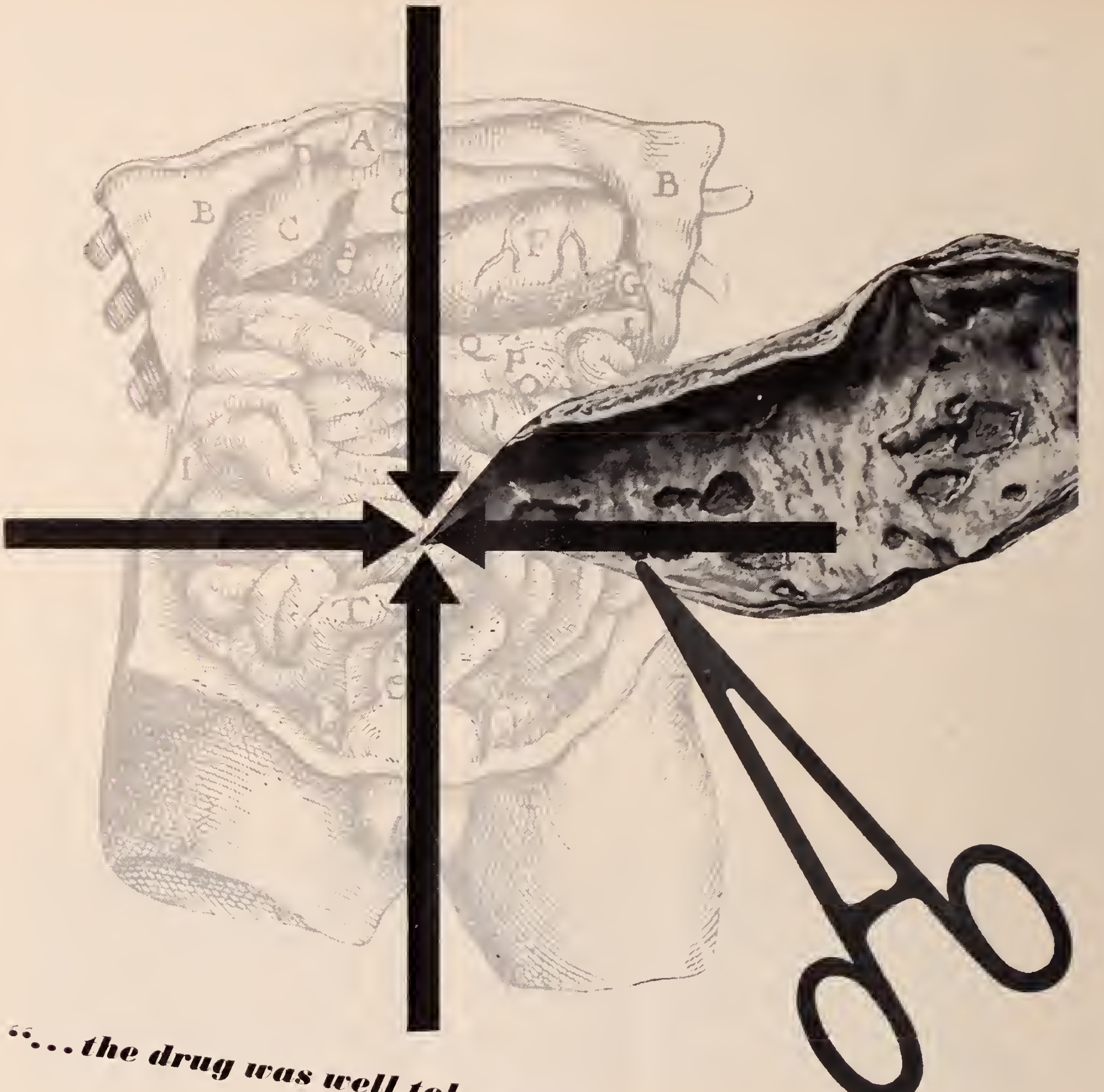
and antibody production apparently are closely linked to quantitative and qualitative protein-adequacy of the diet.* Meat not only is a rich source of proteins, but its proteins, being of highest biologic value, are the RIGHT KIND for antibody production.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

*"It is evident, therefore, that antibody production is but a phase of protein metabolism and that a protein deficiency, whether due to an inadequate protein intake, to protein loss, or to defective protein metabolism, must, in time, impair the maturation or preservation of the antibody mechanism. . . . This means, in turn, that food may play a decisive part in infectious processes in which antibody fabrication is desirable." Cannon, Paul R.: Protein Metabolism and Acquired Immunity, J. Am. Dietet. A. 20:77 (Feb.) 1944.

AMERICAN MEAT INSTITUTE

MAIN OFFICE, CHICAGO...MEMBERS THROUGHOUT THE UNITED STATES



“. . . the drug was well tolerated”[1]

So ran the report on one clinical test of 'SULFASUXIDINE' succinylsulfathiazole in the treatment of bacillary dysentery. Numerous other investigations have demonstrated that 'SULFASUXIDINE' succinylsulfathiazole is promptly effective in reducing temperature and that pathogenic bacteria disappear from the stools of carriers within a week.[2]

This bacteriostatic agent is also accepted as a drug of choice for intestinal antisepsis for patients undergoing surgery of the intestinal tract,[3] since it avoids, under many circumstances, the necessity of multiple stage-operations.

'SULFASUXIDINE' succinylsulfathiazole has low toxicity and high therapeutic concentration in the intestinal tract, since it is poorly absorbed from the bowel.

'SULFASUXIDINE' succinylsulfathiazole is supplied in 0.5 Gm. tablets in bottles of 100, 500, and 1,000, as well as in powder form (for oral administration) in ¼-pound and 1-pound bottles.

Sharp & Dohme, Philadelphia 1, Pa.

1. U. S. Nav. M. Bull. 40:601, 1942 2. J.A.M.A. 119:615, 1942 3. Behrend, M., Surg. Clinics of N. America, Feb., 1944

'SULFASUXIDINE' *Succinylsulfathiazole*

BAXTER—ideally packaged

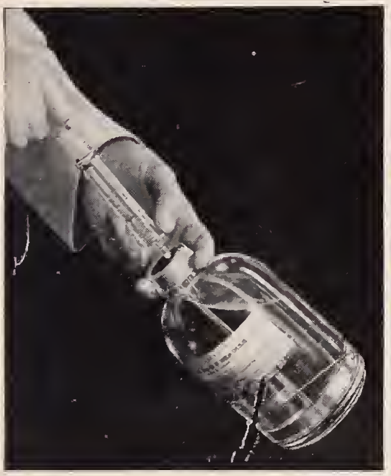
PENICILLIN DILUENTS

STERILE AND NON-PYROGENIC

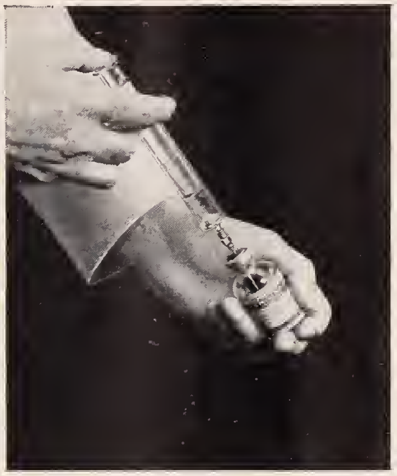
IN VACOLITERS — For continuous intravenous drip infusion.

It is a simple procedure to add penicillin aseptically to the Baxter Vacoliter containing the diluent of choice, such as: Isotonic Solution of Sodium Chloride, U.S.P. (Normal Saline), 5% Dextrose in Distilled Water, or 5% Dextrose in Isotonic Solution of Sodium Chloride, U.S.P. (supplied in 500 cc., 1000 cc. and 2000 cc. sizes).

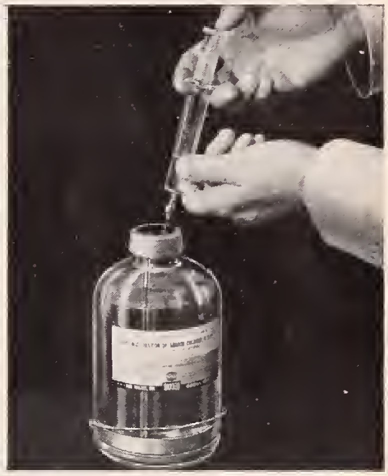
HOW TO ADD PENICILLIN TO VACOLITER ASEPTICALLY



Withdraw small quantity of diluent through open hole of stopper.



Inject into vial or ampul of penicillin to dissolve, then withdraw.



Inject dissolved penicillin through open hole of stopper.

IN RUBBER-STOPPERED VIALS — For intramuscular or intravenous injection by syringe, or for topical use.

ISOTONIC SOLUTION OF SODIUM CHLORIDE, U.S.P. (Normal Saline)
In 10 cc., 20 cc. and 50 cc. Size Vials, in Boxes of 6, 25 and 100 Vials

Rubber-stoppered vial has practical advantages over all-glass ampul as a container for the diluent: No filing required, no danger of glass fragments falling into solution; by means of a sterile syringe and needle the diluent is withdrawn through the vial stopper and then injected into the vial or ampul of penicillin; the dissolved penicillin may then be withdrawn and used parenterally or topically.

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WORLD'S FIRST CHOICE FOR BABIES
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THE SOUTHARD SCHOOL

For the Education and Psychiatric Treatment of Children of Average and Superior Intelligence. Boarding Home Facilities.

TOPEKA, KANSAS

TWENTY-FIVE YEARS AGO

(Continued from Page 36)

surely in foci of infection in other parts of the body, as the gallbladder, appendix, urethra, prostate, stomach, intestines, or elsewhere . . .

Excerpts from Correspondence Health Insurance:

August 2, 1919.

To the Editor:

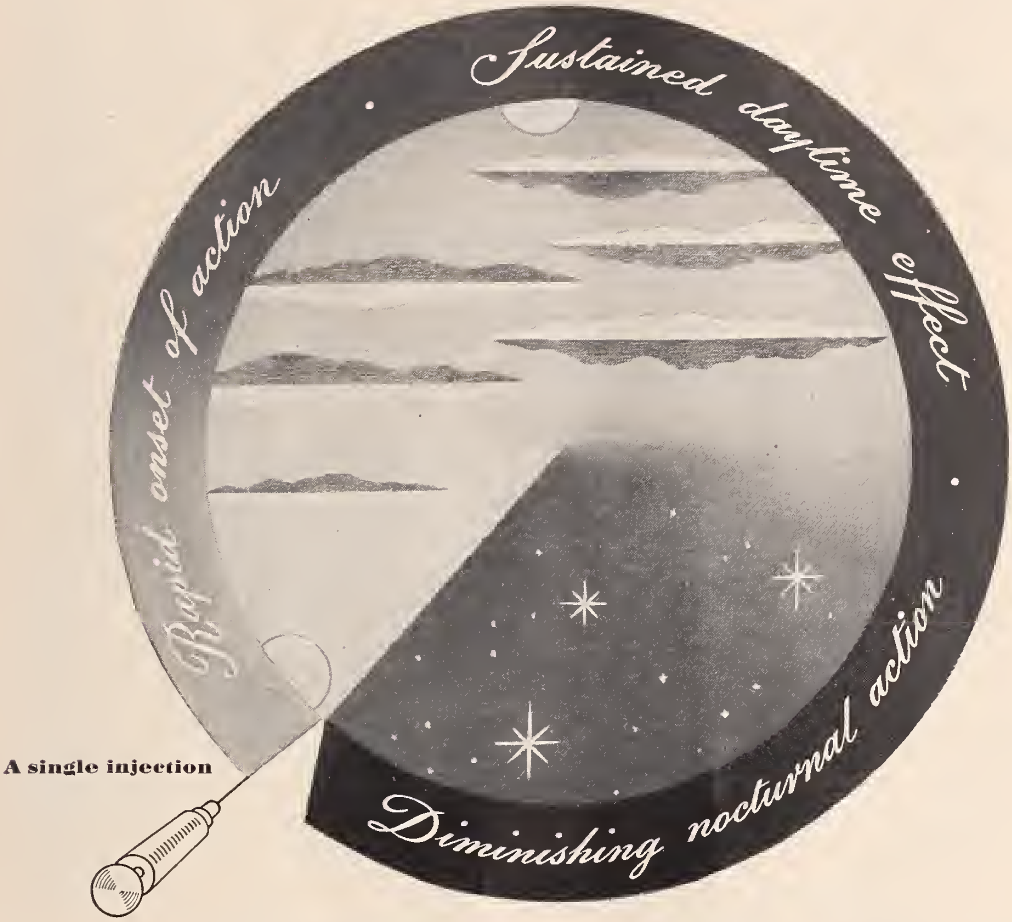
A number of us doctors who battled against health insurance were recently discussing the lack of progress which that movement is making. We were told several years ago by imported and deported propagandists that it was surely coming and that California had just as well be first as last. Riverside county led the procession against it in last year's popular election. Eighty-two per cent of our voters thought just as we did. If we had it to do over again, I am sure we would increase the percentage to ninety-two. The reason for this is set forth so conclusively in an editorial, which I am enclosing from the *Saturday Evening Post* of July 19th, 1919, that I am sure it will be of interest to all if you will publish it. I believe I can say with fullest assurance that it briefly expresses the thoughtful opinion of the medical profession.

(Editor's Note: The following editorial [year 1919] from the *Saturday Evening Post* is published in accordance with the above request:)

"Compulsory State-managed health insurance on the German pattern does not go well here. Americans—wage-earners as much as others—dislike 'compulsory'; they dislike being dry-nursed under the paternal hand of the State. The cost would be high. Many members of

(Continued on Page 42)

Insulin action *timed* to the needs of the day



'WELLCOME' GLOBIN INSULIN WITH ZINC

● As the diabetic goes through the day, his insulin requirements vary. 'Wellcome' Globin Insulin with Zinc provides an action timed to meet these changing needs. An injection in the morning is followed by rapid onset of action which is sustained for continued blood sugar control as the day wears on. Finally by night insulin action begins to wane, minimizing the occurrence of nocturnal reactions.

Many moderately severe and severe cases of diabetes may be controlled with only a single, daily injection of 'Wellcome' Globin Insulin with Zinc. This new long acting insulin is a clear solution of uniform potency. In its freedom from allergenic skin reaction, it is comparable to regular insulin. This advance in diabetic control was developed in the Wellcome Research Laboratories, Tuckahoe, N.Y. U.S. Pat. 2,161,198.

Vials of 10 cc. 80 units in 1 cc.

Accepted American Medical Assn. Council on Pharmacy and Chemistry

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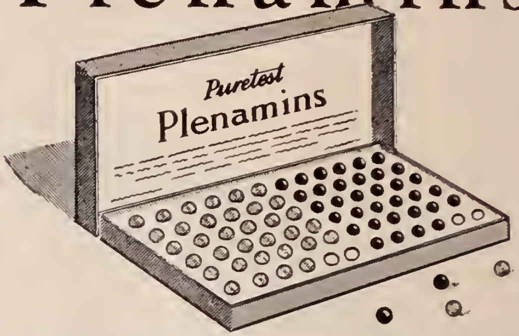

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VITAMIN E
1 Milligram

WITH LIVER & IRON

The Owl Drug Co

131 STORES ON PACIFIC COAST

TWENTY-FIVE YEARS AGO

(Continued from Page 40)

the medical profession object to it. Many workmen believe it would set up an oppressive discrimination against persons who, though not in perfect health, are able to do a very good day's work. Compulsory insurance was decisively defeated in the California prebiscite. It failed in New York." . . .

Excerpt from Immunity: Puts R. A. C. on the Rack
Los Angeles, July 9, 1919.

To the Editor:

Although the reckless impeachment of our profession by R. A. C., who states in the Immunity Column of the July issue of *The Journal* that not one doctor in ten reads the State Medical Journal, will not be taken seriously by any doctor in the State, yet the fact that some lay readers of the *Journal* might be misled compels me to challenge this mendacious statement.

R. A. C. may have been attempting to perpetrate a practical joke, and the initials, for ought I know, may stand for "Rural Asinine Camouflage." Gauged by his expressions, that would seem to be the most appropriate and charitable interpretation. . . .

I also asked each doctor, "Do you know any doctor who receives the *Journal* and whose interest in medical subject is so atrophied that he refuses to read?" The composite reply to this was that they considered it a wanton waste of time to worry over the habits of fossils. That the ambitious doctors, who were coming, or who had already arrived, regularly used the *Journal* to recharge their batteries of information, and that the negligent were a negligible handful.

The apparent trouble with R. A. C. is that he multi-

(Continued on Page 46)

WHAT ARE WE LOOKING FOR?

PARKE DAVIS & CO
RESEARCH IS THE
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In arsenical research we are seeking compounds which offer promise of greater effectiveness against the spirochete of syphilis with less toxicity to the patient . . . a syphilis therapy that will be even better than the dramatically successful Mapharsen* treatment of today. But that is not all we are looking for . . . we are making an exhaustive study of arsenic compounds, searching for the one that may bring amebic dysentery and other diseases of protozoan origin under control, and open up new fields of effective therapeutics.

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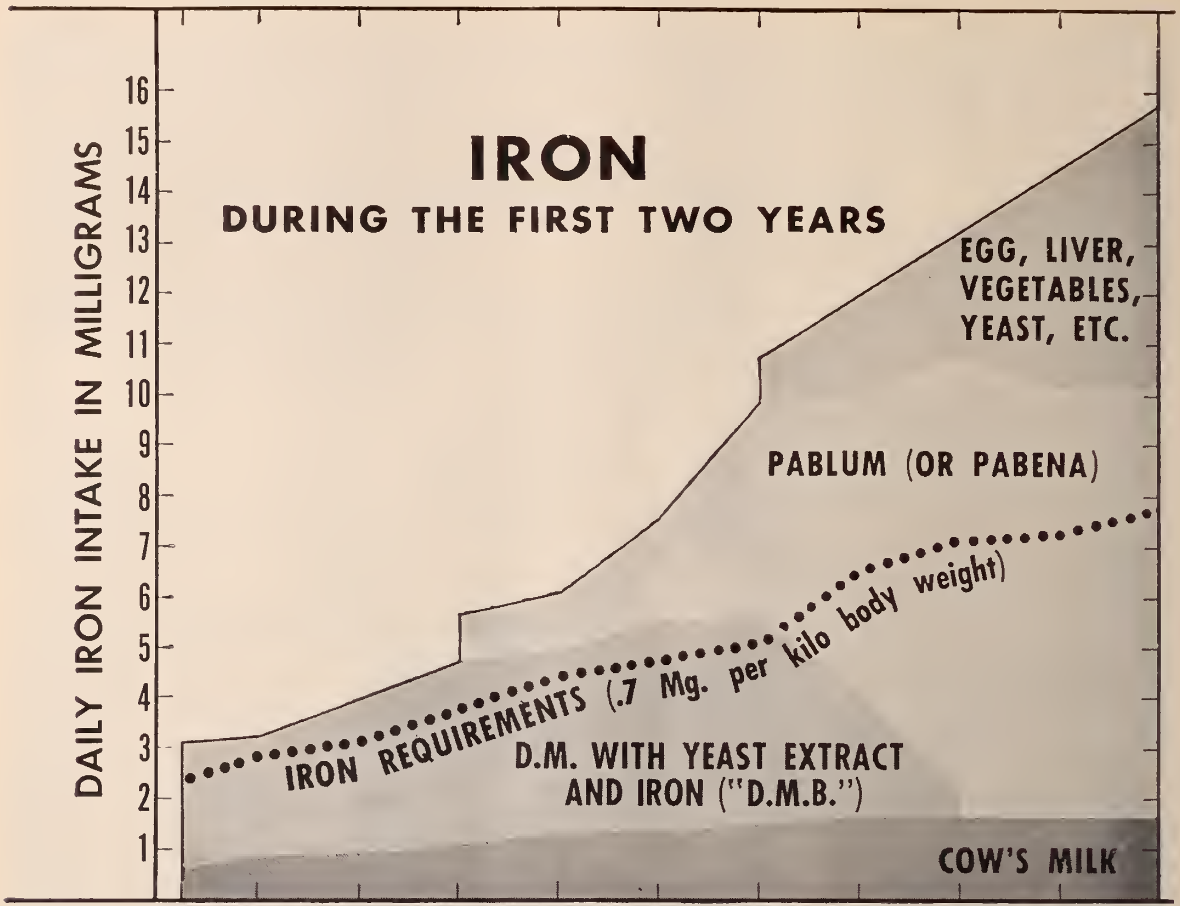

AGE, Mos.	¼	1	2	3	4	5	6	9	12	18	24
WEIGHT, Lbs.	7	9	10	12	14	15	16	19	22	23	25
MILK, Oz.	10	16	18	21	24	26	28	32	32	32	32
"D.M.B.," Oz.	1	1	1¼	1½	1½	1¾	1¾	1	¼	0	0
PABLUM, Oz.	0	0	0	⅛	¼	¼	½	¾	1	1	1

IRON DURING THE FIRST TWO YEARS

During fetal life iron accumulates (in the form of hemoglobin) in the infant's body. After birth the hemoglobin frequently drops to 50% by the third month, especially in prematures. Neither breast milk nor cow's milk is capable of offsetting this loss, as they are deficient in iron. This chart shows that when the carbohydrate and cereal supplements contain iron, a sizeable margin of safety over the requirements can be maintained, not only during the important first six months, but throughout the first two years of life.

More iron than the calculated requirement is needed because some iron is not utilized. In rapidly growing, or poorly nourished infants, and in the presence of infection, the need for iron may be even greater than is indicated in this chart for normal infants.

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SIZE AMPULE
ENICILL
Sodium Salt
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100,000 Oxford U
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Keep Solution at
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To be used only by
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The promise of penicillin . . . precious, life-saving antibiotic derived from *Penicillium notatum* . . . will not be fully realized until this drug is available in sufficient quantities to work its miracles in every city, town, and hamlet in the country.

Cheplin Biological Laboratories are actively engaged in the production of penicillin and are making intensive efforts to increase its output to the point where all restrictions on its civilian use can be removed. We are doing our utmost to speed the day when this drug will be found in every physician's bag and every pharmacist's prescription room.

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Resident Clinicians

TWENTY-FIVE YEARS AGO

(Continued from Page 42)

plied himself instead of using the minus sign. He didn't stop to investigate, he didn't stop to think, but he stopped thinking. Cerebrate, my friend, cerebrate, and you will find that our *Journal* is not only bearing fruit, but sowing seed. That some of the fruit is not picked, and that some of the seed falls on barren ground, is only what betides the best—directed aims and actions that make up "the infinite pathos of human life."

C. J. E.

Medical Uses of Wines and Spirits
Treasury Department
Office of Commissioner of Internal Revnue
Washington, D. C.

June 30, 1919.

Physicians may prescribe wines and liquors, for internal use, or alcohol for external uses, but in every such case each prescription shall be in duplicate, and both copies be signed in the physician's handwriting. The quantity prescribed for a single patient at a given time shall not exceed one quart. In no case shall a physician prescribe alcoholic liquors unless the patient is under his constant personal supervision.

All prescriptions shall indicate clearly the name and address of the patient, including street and apartment number, if any, the date when written, the condition or illness for which prescribed, and the name of the pharmacist to whom the prescription is to be presented for filling. . . .

Trichomonas Vaginalis

TRICH SET

SERVEX INC.

A rational method to combat a very common factor causing leucorrhea in women due to the trichomonas vaginalis.

The dry method of treatment by insufflation using two different prescriptions, one acid, the other alkaline in action.

DIAGNOSIS	ACTIVE INGREDIENTS	PROCEDURE
Acute: Redness, swelling, itching, discharge. Chronic: Discharge, itching. Discharge: Foamy, may be very profuse. Hanging drop or plain slide under oil makes diagnosis definite. Wetsmear: A drop of the vaginal secretion dissolved in about 1c.c. of saline and spread on a slide may reveal the highly motile, flagellated protozoa known as the trichomona vaginalis. Note: Gram stains for G.C. should always be checked.	℞ Bottle #1: Boric Acid Oxyquinoline Sulphate Quinine Sulphate and Nitrophenolate of Mercury ℞ Bottle #2: Kaolin Bicarbonate of Soda Nitrophenolate of Mercury	Office care to get infection under control: Use speculum; wipe vagina clean with cotton. Apply powder alternate days. Frequency of office treatments to be determined by physician. Usually 4-6 treatments. Home care to complete the treatments: Trich set contains 2 powders, a douche and a simple insufflator. Care especially directed to insufflations for 6-8 successive nights after 6-8 successive periods. S-X 12 used by patient morning following insufflation and in aggravated instances, 3 or 4 additional times daily.

File cards on Servex Contraceptives and Servex Trich Set are available to doctors on request. Also write for booklet, "Notes on Contraception."

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A practical antiseptic for the skin should be quick-acting, germicidal in high dilution, sustaining in its action, non-corrosive to the skin and cheap enough to be generally available.

Iodine, in its proper dilutions, meets these criteria. And Iodine has other values. Its activity is practically unaffected by proteins and fats. It is soluble in water and alcohol. Its toxicity is low. Its effectiveness may be expected to continue throughout a prolonged operation.

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Foe of Infection

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SURGERY—Two Weeks Intensive Course in Surgical Technique starting September 18, October 2, and every two weeks throughout the year. One Week Course in Colon and Rectal Surgery starts October 16.

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GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE, SURGERY AND THE SPECIALTIES.

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ATTENDING STAFF OF COOK COUNTY HOSPITAL

Address: Registrar, 427 South Honore Street, Chicago 12, Illinois

TWENTY-FIVE YEARS AGO

(Continued from Page 46)

From an Article on "The Problem of the Woman Venereal Disease Carrier," by Ethel M. Watters, M.D., San Francisco.—When the Federal authorities chose to recognize the danger to the troops presented by the presence of women venereal disease carriers in the vicinities of the army camps, a great step in the fight against these diseases had been taken. In discussing the problem of the woman infected by syphilis or gonorrhea, the fact that both men and women are carriers, should not be ignored; however, the women are the more conspicuous individuals, often passing their lives in response to the demand for illicit sex relations, and they can usually be apprehended readily enough. They form a social group, for which society has but little consideration, whereas their patrons, on whose bounty they subsist, frequently are able by the strength of their social and economic positions to avoid entirely most of the unpleasant consequences of vicious acts. Punishment or care for the women alone, has never and will never solve the problem of eradicating venereal disease. . . .

One characteristic common to most prostitutes is a disinclination for exertion, either mental or physical. They acquire early in their careers habits of idleness and luxury which unfit them to earn their incomes in ordinary decent ways, and, when confronted with the necessity of changing their mode of living, they are completely at a loss, saying frankly that their earning power is not great enough to provide them bread alone. . . .

Perhaps as satisfactory a way of presenting a picture of the prostitute type will be to give some of the more interesting stories in detail. . . .

KOROMEX JELLY
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with Confidence

Through all the years, the name Koromex has always stood for dependability. Koromex Jelly today has attained its highest spermicidal effectiveness. Koromex Cream (also known as H-R Emulsion Cream) is equally effective, and is offered as an aesthetic alternative to meet the physiological variants. Prescribe Koromex with confidence. Write for literature.

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SAN FRANCISCO.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 178)

"Joseph W. Williams, special agent for the California Board of Medical Examiners, today arrested William Edward Gray, 48, of Albany, Calif., on charges of practicing a system of treating sick persons without a license. Gray was released on $500 cash bail after an appearance in police court. Williams said Gray, who allegedly operated offices in Albany and San Francisco, treated patients by touching afflicted spots with his fingers, claiming healing power by his touch. He charged $5 per treatment, and averaged 10 to 15 patients a day at his Vallejo residence, Williams said . . ." (Long Beach *Sun*, July 12, 1944.)

"The city, because of the Naval Hospital, is interested in a report from Rear Adm. George C. Thomas, 11th District medical officer, that Southern California is the Navy's largest medical center. There are more than 17,000 Navy, Marine and Coast Guard patients in this area, and the number soon will pass 21,000, he said. The report states that: 'The Navy Hospital at Long Beach, commanded by Capt. Paul M. Albright (M.C.) U.S.N., has more than 1600 patients. This hospital has won note for its general medical treatment. The other three general medical hospitals of the Navy in this area are at Corona, San Diego and Oceanside. The one at San Diego is the nation's largest Naval Hospital, there being 9000 patients there.'" (Long Beach *Press-Telegram*, July 19, 1944.)

All alike?

RABBIT EYE TESTS* TELL A DIFFERENT STORY!

Edema 0.8 (from PHILIP MORRIS Cigarettes) vs. Edema 2.7 (from *ordinary* cigarettes) clearly reveals the wide difference in irritation caused by different cigarettes.

Equally conclusive are clinical tests.** They have proved over and over again that PHILIP MORRIS Cigarettes are definitely and measurably less irritating to the nose and throat.

Doctor, may we urge you to make your own tests . . . on smokers whose throats are irritated from smoking . . . and *see* PHILIP MORRIS' superiority for yourself!

0.8 . . . *Average edema upon instillation of smoke solution from* **PHILIP MORRIS CIGARETTES.**

2.7 . . . *Average edema upon instillation of smoke solution from* **ORDINARY CIGARETTES.**

PHILIP MORRIS

Philip Morris & Company, Ltd., Inc., 119 Fifth Avenue. New York

**Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245.*
***Laryngoscope, 1935, XLV, No. 2, 149-154.*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—Country Doctor Pipe Mixture. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

Accent on *Velvet Smoothness*

The process used in manufacturing the "RAMSES"* Flexible Cushioned Diaphragm produces a dome which is soft and pliable and can best be described as being as smooth as velvet.

This velvet-smoothness lessens the possibility of irritation during use.

The "RAMSES" Flexible Cushioned Diaphragm is manufactured in sizes of 50 to 95 millimeters in gradations of 5 millimeters. It is available on the order or prescription of the physician through any recognized pharmacy.

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(Continued from Page 3)

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 364 Fourteenth Street, Oakland, 12; 153 Kearny Street, San Francisco; 675 East Santa Clara, San Jose.

Hospital Service of Southern California, 743 South Grand View Street, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles 5. Phone FItzroy 7694.

Note.—The Library of the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, also maintains a medical literature packet service.

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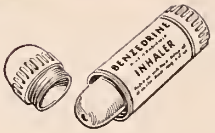

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BOOK REVIEWS

BOOKS RECEIVED

Segmental Neuralgia in Painful Syndromes. By Bernard Judovich, B.S., M.D., Instructor in Neurology, Graduate School of Medicine, University of Pennsylvania; Clinical Instructor in Neurology, Women's Medical College; Chief of Neuralgia Clinics, Philadelphia General Hospital, Graduate Hospital, and Women's Medical College Hospital, Philadelphia, Pa.; and William Bates, B.S., M.D., F.A.C.S., F.I.C.S., Professor of Surgery, Graduate School of Medicine, University of Pennsylvania; Consulting Surgeon, Babies' Hospital and Philadelphia Home for Incurables; Consulting General Surgeon, Wills Hospital, Philadelphia, Pa. Foreword by Joseph C. Yaskin, M.D., Professor of Neurology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa. Cloth. Pp. 313, with 178 illustrations. Philadelphia: F. A. Davis Company, 1944.

Your Eyes. By Sidney A. Fox, A.B., Sc.M. (Ophth.), M.D., Instructor in Ophthalmology, New York University College of Medicine. Cloth. Price, $2.75. Pp. 191. New York: Alfred A. Knopf, 1944.

Metastases Medical and Surgical. By Malford W. Thewlis, M.D., Attending Specialist in General Medicine, United States Public Health Hospitals, New York City; Attending Physician, South County Hospital, Wakefield, Rhode Island; Special Consultant, Rhode Island Department Public Health; Author Care of the Aged (Geriatrics), Preclinical Medicine. Foreword by Hubert A. Royster, A.B., M.D., F.A.C.S., Honorary Chief Surgical Service, Rex Hospital; Chief-of-Staff, St. Agnes Hospital; Consulting Surgeon, Dix Hill State Hospital; Fellow

(Continued on Page 10)

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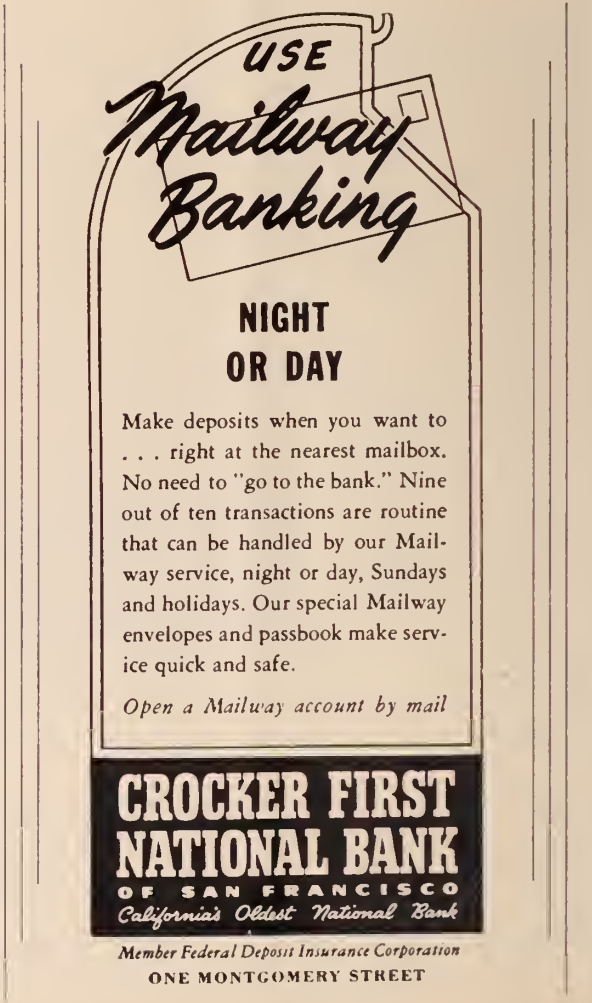

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BOOKS RECEIVED

(Continued from Page 7)

American Board of Surgery, Raleigh. Cloth. Price, $5.00. Pp. 230, with 13 illustrations. Charlotte, North Carolina: Charlotte Medical Press, 1944.

Textbook of Gynecology. By Emil Novak, M.D., F.A.C.S., Associate in Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore. Second Edition. Cloth. Price, $8.00. Pp. 708, illustrated. Baltimore: The Williams & Wilkins Company, 1944.

The Art of Anaesthesia. By Paluel J. Flagg, M.D., Visiting Anaesthetist to Manhattan Eye and Ear Hospital; Consulting Anaesthetist to St. Vincent's Hospital, New York, N. Y.; Consulting Anaesthetist to the Woman's Hospital, Sea View Hospital, Jamaica Hospital, Mount Vernon Hospital, Flushing Hospital, Mary Immaculate Hospital, St. Mary's Hospital, Far Rockaway, N. Y.; Nassau Hospital, L. I.; Director of Pneumatology, World's Fair, New York City, and Chairman of Committee on Asphyxia of the American Medical Association. Seventh Edition. Cloth. Price, $6.00. Pp. 519, with 166 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

Surgical Disorders of the Chest. Diagnosis and Treatment. By J. K. Donaldson, B.S., M.D., F.A.C.S., Major, Medical Corps, Army of the United States; Diplomate American Board of Surgery, Associate Professor of Surgery and in charge of Thoracic Surgery, University of Arkansas School of Medicine, etc., Surgical Staff, St. Vincent's Infirmary and Visiting Staff, Baptist Hospital, Little Rock, Arkansas. Formerly Chest Surgeon to Arkansas State Hospital for Nervous Diseases; Associate Surgeon, Robert B. Green Hospital, Visiting Surgeon to Santa Rosa, Nix, and Medical Arts Hospitals, San Antonio, Texas. Cloth. Price, $6.50. Pp. 364, illustrated with 127 engravings. Philadelphia: Lea & Febiger, 1944.

(Continued on Page 20)

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REFERENCES:

HARDY, A. V.; BURNS, W. and DE CAPITO, T.: Pub. Health Rep. 58: 689 (Apr. 30) 1943.

HARDY, A. V. and CUMMINS, S. D.: Pub. Health Rep. 58: 693 (Apr. 30) 1943.

HALL, W. W.: Am. Drug Mfgrs. Assoc., Annual Convention, Scientific Sec., Hot Springs, Va., May 1, 1944.

Annual Reports, U. S. Pub. Health Service, 1942-43, p. 122.

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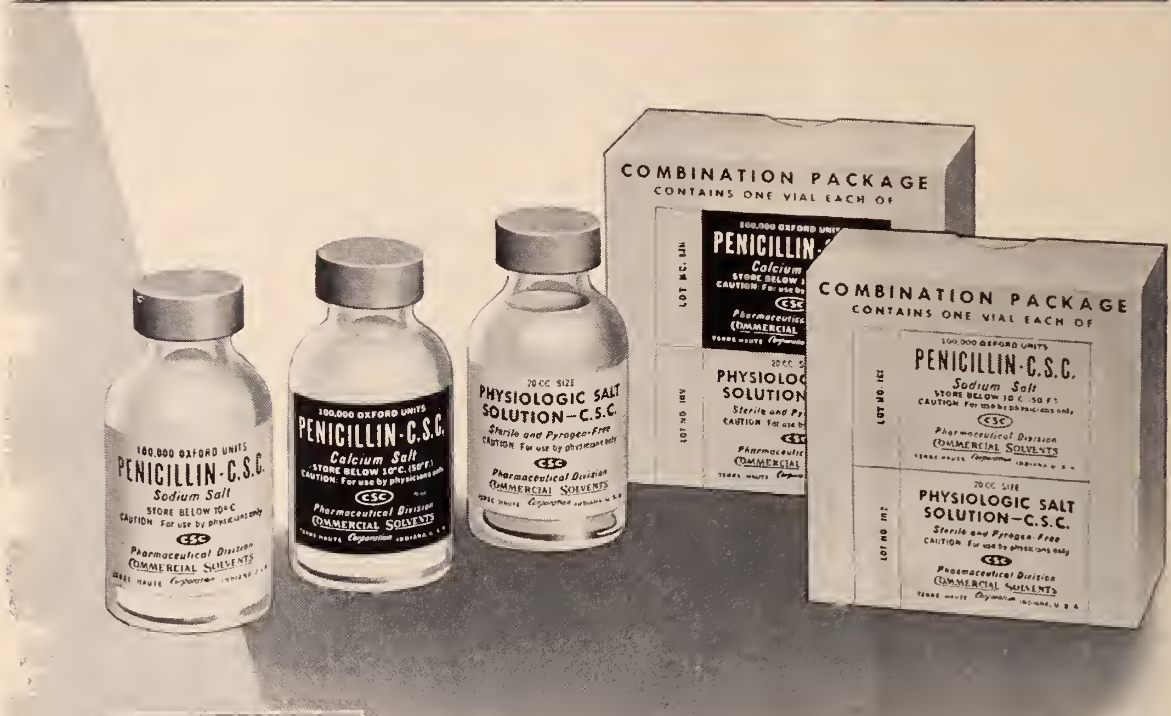
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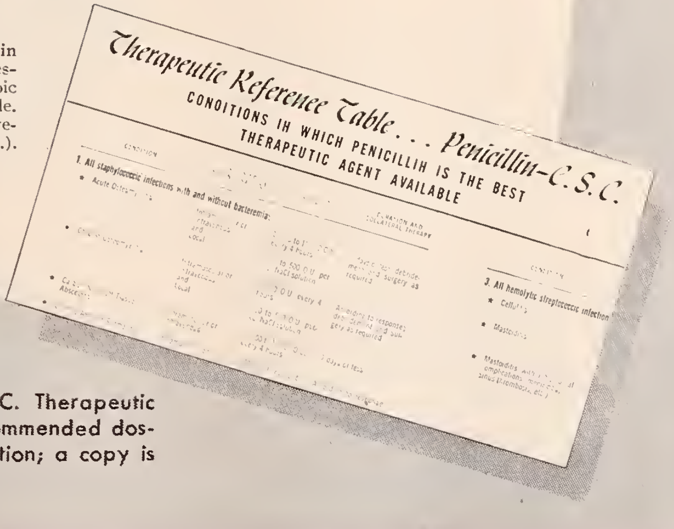

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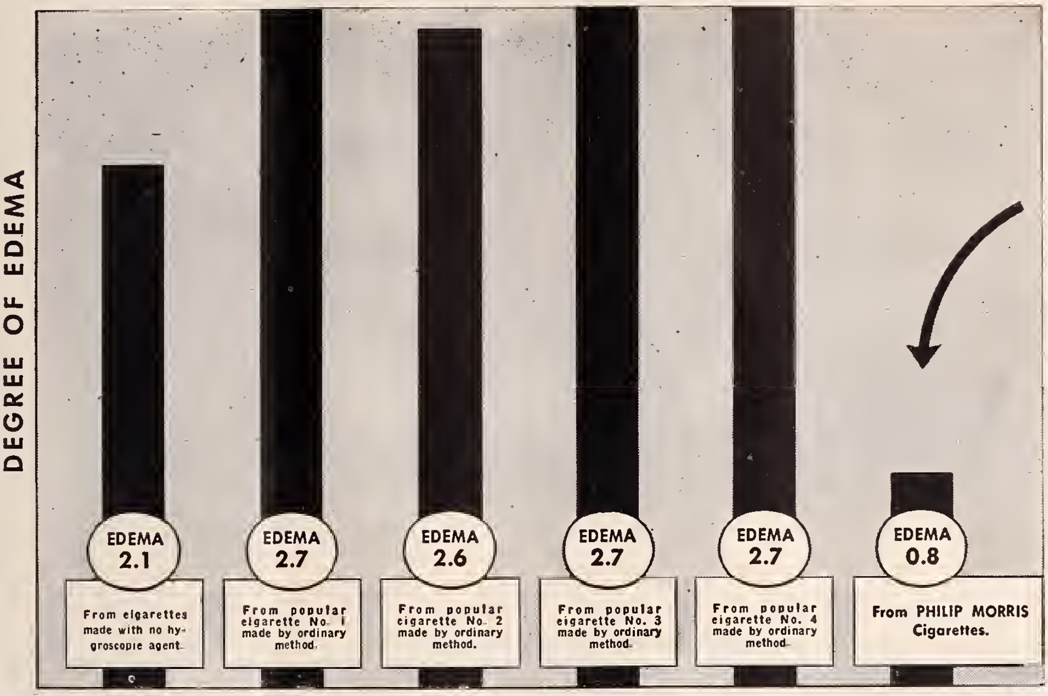

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***N. Y. State Journ. Med. 35 No. 11,590 **Laryngoscope 1935, XLV, No. 2, 149-154**

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BOOKS RECEIVED

(Continued from Page 10)

Civilization and Disease. By Henry E. Sigerist, M.D., D.LITT., LL.D.; William H. Welch Professor of the History of Medicine in the Johns Hopkins University. Cloth. Price, $3.75. Pp. 255, illustrated. Ithaca, New York: Cornell University Press, 1943.

Diseases of the Digestive System. Edited by Sidney A. Portis, B.S., M.D., F.A.C.P., Associate Professor of Medicine, University of Illinois Medical School (Rush); Attending Physician, Michael Reese Hospital; Consulting Physician, Cook County Hospital; Consultant in Medicine to the Institute of Psychoanalysis, Chicago. Cloth. Price, $11.00. Pp. 932, illustrated with 182 Engravings. Philadelphia: Lea & Febiger, 1944.

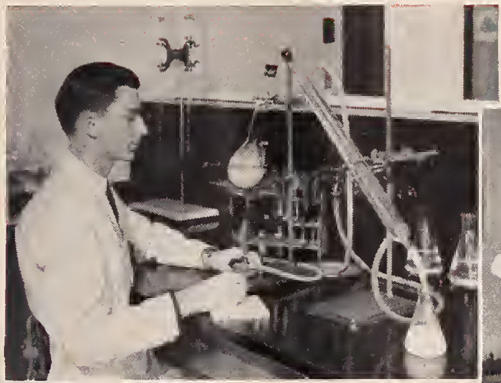
Malaria: Its Diagnosis, Treatment and Prophylaxis. By William N. Bispham, Colonel, U. S. Army, Retired. Cloth. Price, $3.50. Pp. 197, illustrated. Baltimore: The Williams & Wilkins Company, 1944.

The Practice of Medicine. By Jonathan Campbell Meakins, M.D., LL.D., Brigadier, Deputy Director General of Medical Services, Royal Canadian Army Medical Corps; Professor of Medicine and Director of the Department of Medicine, McGill University; Physician-in-Chief, Royal Victoria Hospital, Montreal; Formerly Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Fellow of the Royal Society of Edinburgh; Fellow of the Royal Society of Canada; Fellow of the Royal College of Physicians, London; Fellow of the Royal College of Physicians, Edinburgh; Honorary Fellow of the Royal College of Surgeons, Edinburgh; Fellow of the Royal College of Physicians, Canada; Fellow of the American College of Physicians; Honorary Fellow of the Royal Society of Medicine. Fourth Edition. Cloth. Pp. 1444, with 517 illustrations, including 48 in color. St. Louis: The C. V. Mosby Company, 1944.

Global Epidemiology. A Geography of Disease and Sanitation. By James Stevens Simmons, B.S., M.D., Ph.D., Dr. P.H., Sc.D. (Hon.), Brigadier General, United States

(Continued on Page 26)

WITH AN EYE TO THE FUTURE



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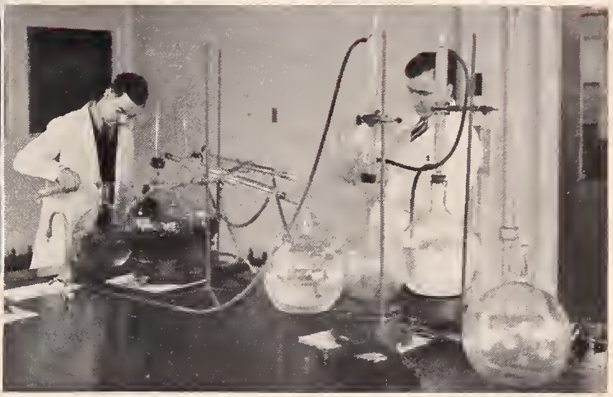

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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BOOKS RECEIVED

(Continued from Page 20)

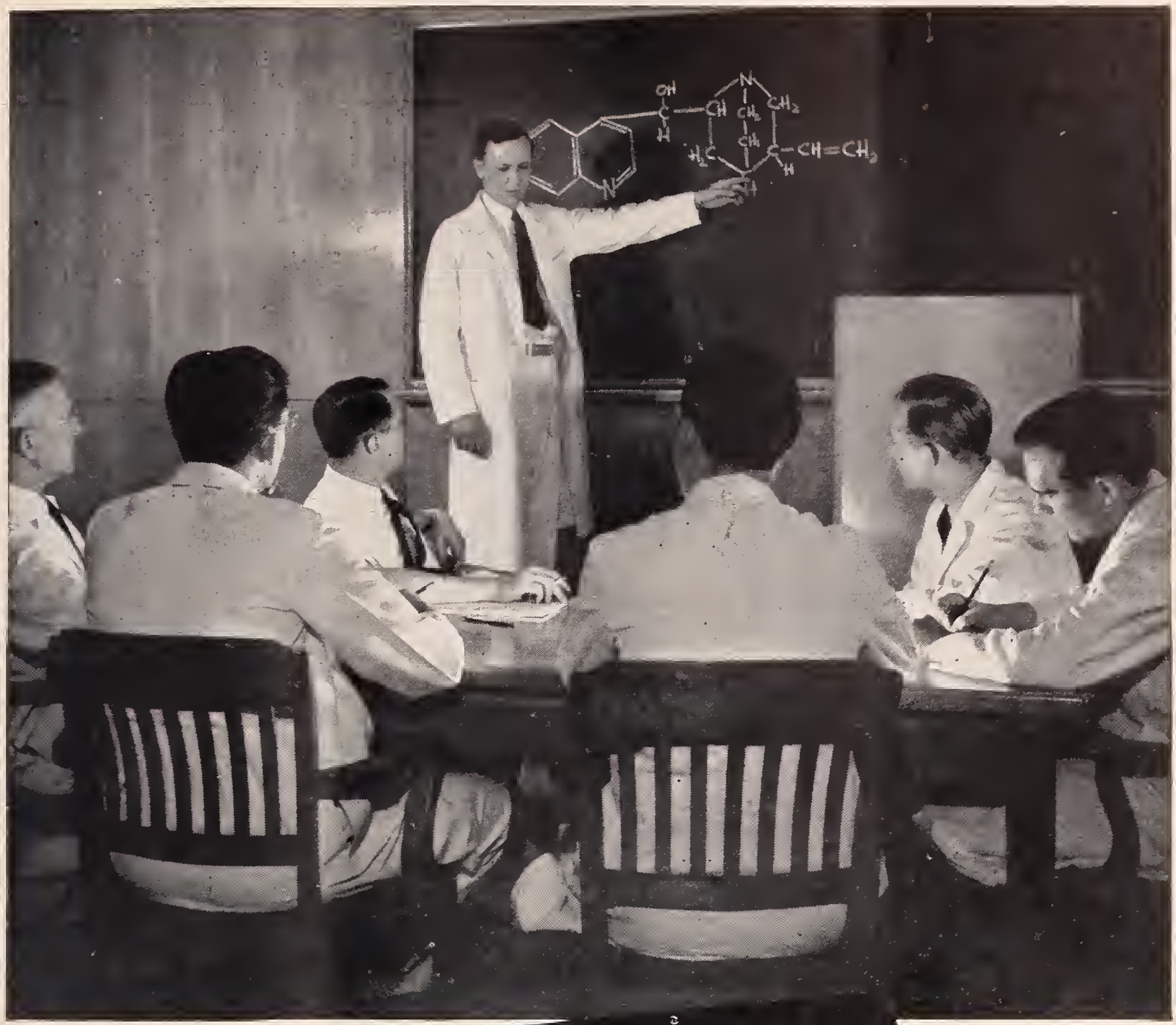
Army; Chief, Preventive Medicine Service, Office of the Surgeon General, United States Army; Member, National Research Council and Committee on Medical Research, O.S.R.D.; Lecturer, Department of Preventive Medicine, Johns Hopkins University Medical School; Lecturer in Public Health, Yale University School of Medicine; Professorial Lecturer in Preventive Medicine, George Washington University Medical School; Member, Visiting Committee, Harvard School of Public Health; Lecturer in Tropical Medicine, Army Medical School. Tom F. Whayne, A.B., M.D., Lieutenant Colonel, M.C., A.U.S.; Formerly Director, Medical Intelligence Division, Preventive Medicine Service, Office of The Surgeon General, United States Army. Gaylord West Anderson, A.B., M.D., Dr. P.H., Lieutenant Colonel, M.C., A.U.S.; Director, Medical Intelligence Division, Preventive Medicine Service, Office of The Surgeon General, United States Army; Director, School of Public Health, University of Minnesota. Harold Maclachlan Horack, B.S., M.D., Major, M.C., A.U.S.; Chief, Dissemination Branch, Medical Intelligence Division, Preventive Medicine Service, Office of The Surgeon General, United States Army; Instructor in Medicine, Duke University School of Medicine, and Collaborators. Volume One: Part One: India and the Far East; Part Two: The Pacific Area. Cloth. Price, $7.00. Pp. 504. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

International Health Division Annual Report 1943. Paper. Pp. 169. New York: The Rockefeller Foundation, 1944.

BOOK REVIEWS

Practical Malaria Control. A Handbook for Field Workers. By Carl E. M. Gunther, M.D., B.S., D.T.M. (Sydney), Field Medical Officer, Bulolo Gold Dredging Limited, Territory of New Guinea, at present with the Australian

(Continued in Back Advertising Section, Page 30)



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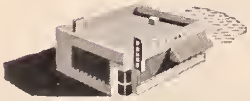

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 61 OCTOBER, 1944 NO. 4

California and Western Medicine

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EDITOR . . . . GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)

Committee on Publications

Francis E. Toomey..........San Diego 1945
George W. Walker (Chairman)..........Fresno 1946
F. Burton Jones..........Vallejo 1947
Secretary-Editor ....ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

PROPOSAL TO LOWER MEDICAL LICENSURE LAWS IN CALIFORNIA!

An Amazing Action by the Postwar Planning Committee.—In the organization section of the *Journal of the American Medical Association* for September 23, 1944, on page 243, appear the minutes of a meeting of the Committee on Postwar Medical Service held on September 9, in New York City. A major subitem was captioned, "Provision for Licensure of Returning Officers," and informs readers concerning a proposal submitted by representatives of: (1) National Procurement and Assignment Service; (2) Council of State Agencies; and (3) Department of Justice.

In essence, the proposition presented would authorize any State Board of Medical Examiners in the United States to give a temporary license (*without examination*) to an honorably discharged medical officer, who had been duly licensed in some other State; the proposed amendment to practically become effective at once, and "to remain in effect until the Governor of a State, on the recommendation of its respective board of licensure, proclaims that this amendment is no longer necessary"!

Another remarkable provision, one that would grant *licensure to physicians in civilian practice, without examination,* (!!) receives separate comment below.

The *J.A.M.A.* gives no information concerning the reasons which led the three government officials to advocate the above recommendations. It may be assumed that their motives were the best.

What is surprising, however, is the fact that the group of nationally prominent Doctors of Medicine, who were recorded as being present—among whom are included the names of present and former officials of the American Medical Association—*unanimously* should have given approval to the proposed and what would be little less than drastic changes in medical licensure for many States of the Union. It is unfortunate that no explanatory comment was offered on why sanction was given by our colleagues, as outlined in the following resolution, which they *unanimously* approved:

"After discussion, the following resolutions were passed unanimously by the Committee on Postwar Medical Service:

"1. That the Committee on Postwar Planning announces its approval of the proposed legislation;

"2. That the Committee recommends that the Council of State Governments be requested to give active support to the proposed legislation in the various States;

"3. That the Committee recommends to State Medical Associations that they support such legislation and that such Associations obtain the assistance of the Procurement and Assignment Service of the War Manpower Commission through its State representatives; and

"4. That the Committee recommends to State Medical Associations that they appoint liaison officers to correlate the efforts of those supporting this legislation."

* * *

Interesting Replies to a California Letter on the Proposed Licensure Changes.—Upon receipt of the *J.A.M.A.* of September 23, a letter was promptly mailed from the office of the California Medical Association to Councilors and other California physicians who had special reasons for being interested in licensure standards, requesting an expression of opinion on the proposed changes in licensure procedures insofar as the best interests of California are concerned. The replies received up to this writing have been *unanimous* as being opposed to amendments of the California Medical Practice Act such as are proposed in the recommendations of the Committee on Postwar Medical Service.

The letters received call attention to facts such as:

(1) The injustice that would be done the 2,151 members of the California Medical Association who have been inducted as Officers of the Medical Corps of the Army and Navy, and the majority of whom are hoping to return, in proper time, to California, and again to build up practices for supporting themselves and their families;

(2) The lowering of standards for licensure, for the maintenance of which the California profession has gone through many hard battles over many years. As is well known, medical licensure standards vary greatly in the different States of the Union. Since all present Doctors of Medicine in California were obliged to conform to existing licensure laws, it does not seem to be, nor is it fair, now to permit an unknown number of physicians licensed in other States to come in, and *without examination,* have the right to practice, since many of such might have been licensed by commonwealths that have less stringent requirements than those of California.

(3) If such amendments were made to the California Medical Practice Act, it is more than possible that many physicians in military service (there are some 50,000 M.D.s in the Medical Corps of the Army and Navy), naturally would avail themselves of the privilege, for where is the physician, in either military or civilian practice, who would not wish to have a license to practice in California, if the legal permission could be obtained *without examination?*

On the other hand, however, it is doubtful whether a large number of names of military colleagues could be secured to a petition, prepared for presentation to the California Legislature, which would ask specifically for the amendments approved by the Committee on Postwar Medical Service. The sense of fair play due military colleagues hailing from California would make most Doctors of Medicine in military service, who are licentiates of other States, refrain from signing such a petition.

(4) Indication of the desire of many physicians to locate in California, even under present licensure laws, is found in the press item of August 28 (some three weeks prior to the *J.A.M.A.* announcement of September 23), which reads as follows:

"Sacramento, Aug. 28, (U.P.)—

"Far more doctors from other states than ever before are applying for 'reciprocity' California medical licenses, the State Board of Medical Examiners said today.

"The Board said the increase probably is due to the fact that many doctors in the military service wish to remain in California after the war; also many doctors in the East and Middlewest are aware that over 4,000 California doctors have entered the armed service in California. These new licentiates could thus be established before the war ends.' "

* * *

Invitation for Presentation of Opposing Views.*—If what has been above stated does not reflect the views of any considerable number of members of the California Medical Association, it is to be hoped any or all such will feel free to write the C.M.A. Council and give their reasons for nonapproval.

At present, for the constituted authorities of the California Medical Association, it may be stated that, in the light of their present knowledge of California licensure, and of their obligation, both to maintain standards of medical practice in California, and also protect the interest of more than 2,000 California physicians in military service, *the constituted authorities of the C.M.A. do not look with favor upon the proposals submitted by the national Committee on Postwar Medical Service.*

If there be some who would advance the argument that such additional physicians might be of service in rural or sparsely settled areas where physicians could be advantageously placed, it may be in order to state that recent licentiates from other States almost always seem to prefer the metropolitan or other California cities, where an inadequate supply of physicians does *not* exist. Let it be remembered, also, in California there is no law that makes it mandatory for a physician to practice in that community or area where his services might be most needed. Whatever influence, today, is wielded in such direction, rests largely on moral suasion, and not on legal authority.

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* For excerpts from reply letters, turn to page 211.

* * *

Amendment likewise recommends that Civilian Physicians who have Rendered Medical Service "in Industry or in a Civilian Community" may be eligible for Licensure without Examination! This Makes Possible a Breakdown of all State Medical Practice Acts!! Why are such Licensure Amendments proposed?—What has been written above was intended to apply only to Doctors of Medicine in military service.

Even more astounding is the recommendation of the three governmental agencies that *"If an applicant presents evidence satisfactory to the board [a State Board of Medical Examiners] that he . . . has rendered medical service during the period 1940 to 1945 in industry* [!] *or in a civilian community* [!!] *. . . the board [a State Board of Examiners] in its discretion may issue him a temporary license" . . . etc.*

If the inclusion of provisions to make physicians in civilian practice (industry or non-industry) *eligible for a license to practice, without examination,* does not mean that the system of medical licensure, as brought into being in the different States of the Union after almost a century of struggle, will be broken down and practically nullified, then what does such phraseology mean?

The more the scope and implications of the proposed amendments are studied, the more incomprehensible do they become!

And equally nonunderstandable is it,—How it came to pass that *unanimous sanction* was given such proposed amendments by the group of prominent medical colleagues, whose past services on behalf of medical practice and the public health were so notable as to have brought to them some of the highest honors of the profession?

In short, the more the item on page 243 of the *Journal of the American Medical Association* for September 23 is read, the more difficult it becomes to tabulate sound reasons on why the actions there noted, were taken.

* * *

Objective Judgment Needed In So Serious a Recommendation.—In conclusion, it can be said that, to a considerable number of California physicians it seems, while the proposed licensure amendment may represent a fine spirit of emotional desire to show appreciation to colleagues who have given up civilian practice to serve our Country at the front, the proposals do not rest upon conclusions that have been reached after careful, mature and objective study of existing laws, the reasons that brought them into being, and the effects lower standards of licensure would have on present and future standards of medical practice.

It is granted that California today, as a place of residence, may have special and more lure, for many, including even Doctors of Medicine who are licensed to practice elsewhere, than any other State in the Union. Also, after the Duration, it is possible that some States may have fewer physicians than at the beginning of World War II. Such States may welcome the proposed amendments.

Nonetheless, the press item of a month ago and quoted above proves that such will not be the experience of California. Properly qualified Doctors of Medicine who pass the existing California licensure laws have been and are welcomed by physicians now practicing in this State. Because the California Medical Association has fought for proper licensure laws and high standards of practice over many years, its members will wish good reasons submitted before going on record in support of lesser standards. Wherefore, for the time being, *the constituted authorities of the California Medical Association do not give approval to the request that California take steps to bring about the enactment of the proposed amendments.*

ON VARIOUS TOPICS

U. S. Senate Hearing and C.P.S.; Nagging Officiousness; Industrial Accident Work Fee; Schedule Increased By 15 Per Cent Surcharge; Four Symposia on Wartime Medical Topics; P. and A. Clearance as a Requirement For Membership in County Medical Societies; Announcements of Major Political Parties Concerning Public Health and Medical Service Policies; Bubonic Plague in California; Anti-Vivisection Activities in Washington, D. C. and Chicago

U. S. Senate Hearing and C.P.S.—On September 18-20, in Washington, D. C., the U. S. Senate Committee on Wartime Health and Education held hearings on activities related to the public health. Senator Claude Pepper of Florida, chairman of the Senate Committee, invited Dr. T. Henshaw Kelly, Secretary of the Trustees of California Physicians' Service, to appear before the Senate Committee and give informative and other data concerning California Physicians' Service, the Statewide medical service plan brought into being by the California Medical Association. Because of the importance and implications of the issues under discussion, the attention of members of the California Medical Association is called to Dr. Kelly's report on some phases of the hearings that are related to medical service plans. His report appears in this issue on page 207. The *J.A.M.A.* for September 23, on page 244, in its Washington letter of September 18, also presents comments on the hearings.

Doctor Kelly's report on C.P.S. has special value because it indicates some of the current trends in thought, as expressed by some Congressional representatives of the law-making branch of the Government. Since the subjects under consideration are of great importance to the medical profession of the United States, the report by Dr. Kelly has been given place in the Original Article department of the current issue, in order that other medical society and service groups throughout the United States may have oportunity to scan the same.

* * *

Nagging Officiousness.—In the Letters Department of the current number is printed a copy of a letter dated September 25th, sent by Dr. Harold A. Fletcher, California State Chairman for Physicians' Procurement and Assignment Service to Dr. Paul C. Barton, Executive Officer of the central Procurement and Assignment Service in Washington, D. C. In his letter, Dr. Fletcher directs attention to procedures which would make it necessary for physicians to register, and write additional paper reports.

In these busy days, many physicians are rendering professional courtesies to colleagues, when the doctors called upon, because of more immediate responsibilities, are themselves unable to respond. For the letter referred to, see page 226.

Dr. Fletcher is to be commended not only for his forthright statements, but for the service he has rendered in calling the attention of the Washington authorities to the annoying officiousness of representatives of the Social Security Board. Physicians should take the time to read the letter. Naturally the thought arises,—Are the conditions criticized by Dr. Fletcher a foretaste or sample of what medical men may experience, if compulsory governmental medicine is put in operation?

* * *

Industrial Accident Work Fee Schedule Increased by 15 Per Cent Surcharge.—Minutes of the 320th meeting of the C.M.A. Council (CALIFORNIA AND WESTERN MEDICINE, for September, page 153, Item 10) gave information concerning conferences with the California Industrial Accident Commission and other groups. Also, that the California Industrial Accident Commission had officially authorized a 15 per cent surcharge on fees for professional services rendered to patients coming under the jurisdiction of the industrial accident laws of California. The component county societies of the California Medical Association have been so notified. However, one or two commercial carriers seem reluctant to abide by the ruling of the State Industrial Accident Commission. Such instances should be reported to the central office of the California Medical Association.

The following is one of several resolutions adopted by county medical societies:

RESOLUTION OF SAN JOAQUIN COUNTY MEDICAL SOCIETY

WHEREAS, The industrial accident rates for medical services have not been increased for the last 24 years; and

WHEREAS, The costs of rendering these services have materially increased during this long period of time; therefore be it

Resolved, That the San Joaquin County Medical Society does hereby endorse the 15 per cent surcharge authorized by the Industrial Accident Commission of the State of California, as a partial compensation for these increased costs; and further

Resolved, That all members of this Society include this 15 per cent surcharge on all statements for medical services rendered to industrial accident patients as of August 1, 1944, as authorized by the California Industrial Accident Commission. (See letters on p. 215.)

* * *

Four Symposia on Wartime Medical Topics.—The current issue carries the first of four symposia on wartime medical topics. Reference was made to these, in reports submitted by the Editorial Board to the C.M.A. Council (references: CALIFORNIA AND WESTERN MEDICINE, for June, page 325, Item 13; and CALIFORNIA AND WESTERN MEDICINE, for September, page 153, Item 9). The symposia were gathered under the supervision of special committees: (1) Civilian Defense, Dr. Henry Gibbons, III, San Francisco; (2) Communicable Diseases, Dr. Edward B. Shaw, San Francisco; (3) Nutritional Topics, Dr. Dwight L. Wilbur, San Francisco; (4) Industrial Problems, Dr. Rutherford T. Johnstone, Los Angeles.

The symposia will probably appear in the order indicated. Because of the lesser size of the OFFICIAL JOURNAL, due to governmental directives designed to alleviate paper shortage, the symposia, during the next four months, will use all available space in the department allocated to original articles. Thereafter, papers presented at this year's annual session, and before county societies, will again receive consideration for publication.

Thanks are extended by the Editorial Board to all who participated in the collection and preparation of the articles that will appear in the symposia.

* * *

P. and A. Clearance, as a Requirement for Membership in County Medical Societies.—Component County Medical Societies that have taken no action to date, may wish to give consideration to prospective by-laws laying down,—for this wartime period, at least,—a new requirement to apply to applicants for county society membership. The principles and issues involved are worthy of careful thought.

A paragraph from a letter sent out by Dr. Harold A. Fletcher, Physicians' Procurement and Assignment Service chairman for California, gives the following information:

"Over a year ago, in discussing this problem with my San Mateo County Chairman of Procurement and Assignment Service and the San Mateo County Medical Society, the San Mateo County Medical Society passed a resolution which would debar new applicants from membership in the San Mateo County Medical Society who located in San Mateo County, in areas or locations where their services were not considered by Procurement and Assignment Service as definitely essential.

"This resolution, which was adopted, has had a very helpful effect in getting new physicians wishing to locate in San Mateo County to take definite locations where they were needed, or in causing them to locate in some other county where their services were very much needed.

"It has also had the general all-over effect of assuring physicians from San Mateo County who are on active duty with the military forces, that their practices would be, to a certain degree at least, protected and preserved against their return."

A resolution of the Santa Clara County Medical Society follows:

> WHEREAS, There are at present communities in which there is great need for civilian medical personnel; and
>
> WHEREAS, The procurement and assignment service is unable to assign physicians to these needy localities; and
>
> WHEREAS, There may occur situations in which areas vacated by physicians in the armed forces are exploited for personal advantage by physicians arriving from localities outside of Santa Clara County; therefore be it
>
> *Resolved*, That applications for membership in the Santa Clara County Medical Society shall, for the duration of the present emergency, be approved only when the applicants have been certified by the Santa Clara Procurement and Assignment Committee as "locally essential" in the community in which they practice, or propose to practice."

* * *

Announcements of Major Political Parties Concerning Public Health and Medical Service Policies.—During recent years, the system of medical practice that has long been in vogue, and through which American Medicine has been able to give to citizens of the United States,—in spite of the magnitude of the diversified topographic, climatic, economic and social environments the lowest morbidity and mortality records of any of the civilized lands and peoples,—has been marked for succeeding attacks by theoretical and other groups, who have worked out blue prints for a changed relationship they hope to bring into being for the medical profession.

Or, to put it otherwise, in recent years, American Medicine has been subjected to repeated assaults from political angles. This is a new experience to many physicians. Proponents of the new plans have carried their propaganda into the Congressional halls, and are vigorously advocating enactment of laws which, if applied, would make, not for better but for poorer medical practice and care of citizens. Since this is the case, then, whether American Medicine likes it or not, its disciples must begin to take an active interest in political alignments that have relation to medical practice.

In that spirit, and in full nonpartisanship, excerpts from the platforms and announcements of the Democratic and Republican parties were given in CALIFORNIA AND WESTERN MEDICINE in the issues of August (page 113) and September (page 159). In the current issue (on page 225) appears an interesting statement made by Governor Thomas E. Dewey, taken from his speech given in the Los Angeles Coliseum on September 22nd. It is heartening to read the following statement:

> "We must help to develop a means for assurance of medical service to those of our citizens who need it, and who cannot otherwise obtain it.
>
> "This is a task that must be carried out in coöperation with our medical men. *There can be no group better able to advise on medical care than the medical profession.*"

Bubonic Plague in California.—Many younger members of the California Medical Association have only a vague understanding of the seriousness of the California bubonic plague outbreak which started in 1900 in San Francisco. In the Twenty-Five Years Ago and Letters departments of CALIFORNIA AND WESTERN MEDICINE, references have been made thereto in the past.*

More recently, in a lay publication (*American Mercury*, for September, on page 312) appeared an illuminating article from which liberal excerpts have been made, these appearing in the current number of CALIFORNIA AND WESTERN MEDICINE, on page 218. (For other references, see footnote.*)

As there stated, sylvatic plague (plague of rodent animals) is now a widespread disease. The outbreaks of bubonic and pneumonic plague which have occurred in past years in the cities of San Francisco, Oakland and Los Angeles should be a warning to physicians throughout the Western States to be on guard. The U. S. Public Health Service and the State Boards of Public Health have spent thousands of dollars in work designed to keep the disease under control. In the fight against the *Bacillus pestis*, one cannot be too vigilant.

* * *

Anti-Vivisection Activities in Washington, D. C., and Chicago.—CALIFORNIA AND WESTERN MEDICINE, in the September number, gave space to a brief article by Publicist Chester Rowell of California, on the anti-vivisection campaigns recently carried on in the Nation's capital, and in Chicago. In the C.M.A. files were some copies of the articles by Dr. A. C. Ivy of Northwestern University, printed some years ago in CALIFORNIA AND WESTERN MEDICINE. Copies of Dr. Ivy's excellent portrayals of what scientific animal experimentation has done in protection of the health and lives of human beings, and also of lower animals, were sent to Senator William Langer and Representative Burdick of North Dakota. Reference is made to the short article by Mr. Rowell because it is worthy of perusal. (See September issue, on page 163.)

What profit a man to know Plato and Aristotle when confronted with the cold, flat fact of making a living? An empty negative, if you must judge by the standards of the market-place; but there are other values; and if these distracted times prove anything, they prove that the greatest illusion is reliance upon the security and permanence of material possessions. We must search for some other coin. And we will discover that the treasure-house of education has stood intact and unshaken in the storm. The man of cultivated life has founded his house upon a rock. You can never take away the magnificent mansion of his mind.—John Cudahy.

"It is not to be imagined that he should know the remedies of diseases who knows not their original causes."—*Aurelius Cornelius Celsus.*

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* For article on Bubonic Plague outbreak in year 1900 see CALIFORNIA AND WESTERN MEDICINE, for February, 1939, on page 121. Footnote thereto gives additional references.

EDITORIAL COMMENT†

PENICILLINASE

After grinding the bacteria in a ball mill, Abraham and Chain[1] extracted an intracellular enzyme-like substance from *E. coli.* This extract was capable of completely inhibiting the in vitro bactericidal properties of penicillin. Harper[2] extracted an even more effective "penicillinase" from the paracolon bacillus. The British investigators could demonstrate no penicillinase, however, in penicillin-susceptible strains of staphylococci,[3] nor in staphylococcal cultures made penicillin-resistant by serial growth in the presence of increasing concentrations of penicillin. Penicillinase, therefore, was apparently of no practical clinical interest in staphylococcal infections.

The opposite conclusion is currently reported by Kirby[4] of Stanford University Hospital, San Francisco, from a study of initial staphylococcus aureus cultures isolated from patients subjected to penicillin therapy. All of his cultures were obtained before beginning the penicillin therapy, so as to rule out the phenomenon of acquired penicillin-resistance. Seven in vitro penicillin-refractory strains and 7 penicillin-susceptible cultures were selected for detailed study. Adopting Harper's[2] extraction technique a crude powdered extract was prepared from each culture. Confirming results reported by the British investigators,[3] Kirby found that the powdered extract from penicillin-susceptible strains contained no demonstrable trace of penicillinase. Even 2 mg. of the powdered extract added to as little as 1 unit of penicillin in no way reduced its bactericidal titer.

A quite different result was obtained with powdered extracts from penicillin-refractory strains. Here as little as 1 mg. of the powdered extract completely destroyed the bacteriostatic properties of at least 100 units of penicillin (higher number of units not tested). Confirming these findings Kirby found that actively growing cultures of refractory strains of staphylococci cause a complete destruction of penicillin in the culture medium. Such destruction is apparently wholly intracellular, since seitz filtrates of such cultures contain no demonstrable traces of penicillinase.

The penicillin-destroying enzyme is completely inactivated by heating to 56° C. for 60 minutes. Whether or not the staphylococcal penicillinase is antigenic and identical with penicillinase isolated from the colon or paracolon bacillus is as yet undetermined. Penicillinase has proved to be a valuable adjuvant to routine culture media, making possible successful blood cultures or exudate cultures from patients during the course of penicillin therapy. Study of the possible penicillinase content of nonstaphylococcal infections is now in progress in the Stanford Laboratory.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

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4. Kirby, W. M. M., Science, 99:452 (June 2), 1944.

Socialized Medicine

It is but natural that American doctors should oppose Federal socialization of medicine. They have seen such systems curb incentive and progress in the medical field in other nations, and remove the personal relationship between doctor and patient, leaving in its stead an official system as impersonal as medical examinations as Army induction centers. If that's what this nation wants, socialized medicine will fill the bill. But the people should remember that it is not the doctors, but Mr. and Mrs. John Jones who will be the losers.

In seeking a practical method for voluntary prepayment of medical costs to meet prolonged or serious illness, the public should not be misled by alluring promises of "free medicine" at the hands of the State. There can be, however, the fullest coöperation between Federal and local governments, industry, the people and the medical profession, to extend voluntary methods of health insurance without the regimentation and compulsion that inevitably follows socialized medicine.

Government can help solve such problems as malnutrition, bad housing, and the inadequacy of Federal, State and municipal health programs. One of the legitimate functions of government is to seek ways and means to correct social and economic conditions which cause disease, and which all the health insurance in the world will not remedy.

Therefore, let us retain the great advantages of private medicine but add to them the benefits that will accrue from the coöperation of government and industry in eliminating causes of illness, as well as providing easy and economical methods of paying for it.—San Francisco *Underwriter's Report,* August 31.

"Facts About Nursing": A New Booklet.—Facts About Nursing, 1944, a practical handbook of essential data about nursing, points up the growth of hospital, health and nursing services as well as of nursing schools in recent years and suggests trends of special interest to those concerned with postwar planning.

According to the 1944 Facts, approximately 208,000 registered nurses are serving civilians in this country. Another 48,000 are in military service; of these nearly 23,000 are overseas. Departments of the Federal Government, exclusive of the Army and Navy, employed over 6,500 nurses in 1943, and the employment of over 7,500 has been authorized for the current fiscal year.

The price of the *1944 Facts* is $0.25. Copies may be ordered from the Nursing Information Bureau of the American Nurses' Association, 1790 Broadway, New York 19, New York.

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

ORIGINAL ARTICLES

Scientific and General

A PERMANENT EMERGENCY MEDICAL SERVICE FOR DISASTER RELIEF†*

Lieut. Commander Henry Gibbons, III (MC), U.S.N.R.
San Francisco

The War has brought sharply to focus the need for a permanent organization for disaster relief in civilian communities. Since the beginning of the war several disasters have been handled by Civilian Defense Organizations and have thus proved this need. The adoption of a permanent organization, therefore, based on the present Civilian Defense set-up, seems desirable. (See references.)

If some thought and preparation are given to preparedness, there cannot be the six hours of chaos and confusion that have been known to exist in the past after a disaster.

This issue of the California and Western Medicine deals with the Emergency Medical Service. Rescue work is a separately-trained and operated division, that must function in close coöperation with the Medical Division. Housing, food, clothing, etc., are problems handled by the Emergency Welfare Services and the Red Cross Disaster Relief Service.

Successful emergency medical work depends on three important things:

1. The persence of a Mobile Medical Team at an incident.
2. Prompt and adequate ambulance service.
3. Immediately available medical care at the hospital or casualty station.

First-aid procedures, in the field of communities with hospital service available, are restricted to stopping hemorrhage, immobilization of fractures by simple and quick splinting, prevention of shock, and relief of pain with opiates if necessary. First-aid stations are usually not desirable, since adequate treatment can be given only in hospitals. Rapid transportation of all injured to the hospital is the best procedure. Casualty stations can be operated in isolated districts remote from a hospital, or near a hospital in order to handle the minor injured and prevent overcrowding of hospital facilities. They are staffed with doctors and nurses.

The Emergency Medical Service for Civilian Defense is made up of doctors, nurses, dentists, and auxiliary personnel, each with a specific assignment. It is now opportune to plan to continue an active roster of doctors and nurses, and such auxiliary personnel as may be needed for each unit. All professional people can easily continue this specific assignment to a hospital or casualty station accessible to them, with the understanding that they are to report there in case of emergency.

There are three important sections comprising the Emergency Medical Service:—

The Field Casualty Section.
The Hospital Section.
The Nursing Section.

FIELD CASUALTY SECTION

The Field Casualty Section consists of:

I, a Field Casualty Service (with its Mobile Medical Teams and equipment, organized at hospitals), stretcher teams, casualty stations, ambulances and other transport;

II, a Casualty Information Service; and

III, an Emergency Mortuary Service.

This section also maintains a source of supply of blood plasma for the field.

HOSPITAL SECTION

Arrangements with general hospitals for the maximum expansion of their normal facilities for the reception and care of casualties in an emergency should be maintained. Hospital traffic must be controlled with the help of the regular or auxiliary police.

NURSING SECTION

The Nursing Section is responsible for nursing participation in the Emergency Medical Service. Nurses are listed and classified in the local communities, so that in an emergency they may be mobilized for immediate duty. This work is done

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† **Explanatory Note.** Concerning Four Symposia to appear in issues of October, November, December and January.

In every war there is a tendency to neglect the health, the safety, and the nutrition of those who are behind the lines. Famine and pestilence are facts of war and can be crucial factors in victory or defeat. Our present war is so large and is lasting so long that we will need to be especially alert well beyond the cessation of hostilities.

With the desire to promote optimal health in our civilian population four symposia have been compiled. These have been gathered as follows: (1) Symposium to appear in October issue, on Disaster Relief, by Henry Gibbons, III of San Francisco; (2) Symposium in November issue, on Communicable Diseases, by Edward B. Shaw, of San Francisco; (3) Symposium in December issue, on Nutritional Problems, by Dwight L. Wilbur, of San Francisco; (4) Symposium in January issue, on Industrial Medicine, by Rutherford T. Johnstone, of Los Angeles.

A special committee, appointed for this project by Council Chairman Gilman, consisting of Howard F. West, J. Homer Woolsey, and Fletcher B. Taylor, chairman, wishes to express sincere gratitude for the work done by each contributor.

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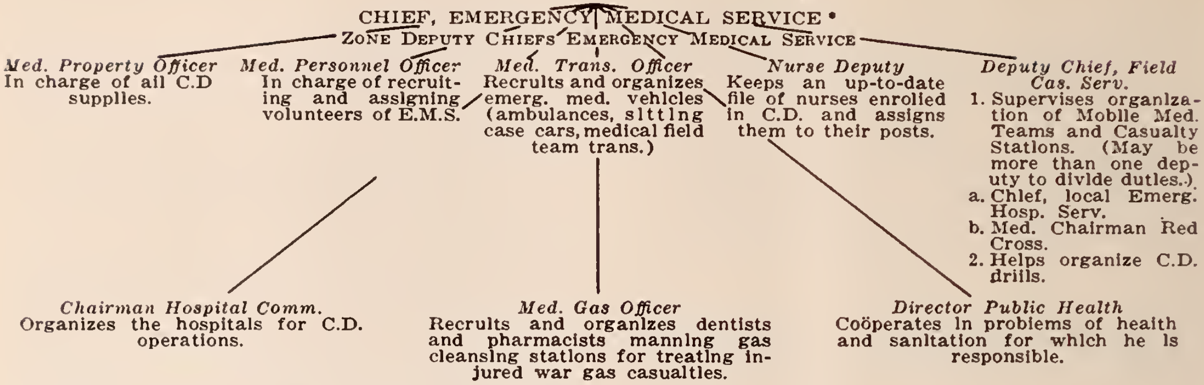
* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

From the Office of the Chief of the Emergency Medical Service for San Francisco Civilian War Council.

TABLE 1.—*Diagram No. 1: Plan of Organization*



CHIEF, EMERGENCY MEDICAL SERVICE *

ZONE DEPUTY CHIEFS EMERGENCY MEDICAL SERVICE

Med. Property Officer
In charge of all C.D supplies.

Med. Personnel Officer
In charge of recruiting and assigning volunteers of E.M.S.

Med. Trans. Officer
Recruits and organizes emerg. med. vehicles (ambulances, sitting case cars, medical field team trans.)

Nurse Deputy
Keeps an up-to-date file of nurses enrolled in C.D. and assigns them to their posts.

Deputy Chief, Field Cas. Serv.
1. Supervises organization of Mobile Med. Teams and Casualty Stations. (May be more than one deputy to divide duties.)
a. Chief, local Emerg. Hosp. Serv.
b. Med. Chairman Red Cross.
2. Helps organize C.D. drills.

Chairman Hospital Comm.
Organizes the hospitals for C.D. operations.

Med. Gas Officer
Recruits and organizes dentists and pharmacists manning gas cleansing stations for treating injured war gas casualties.

Director Public Health
Coöperates in problems of health and sanitation for which he is responsible.

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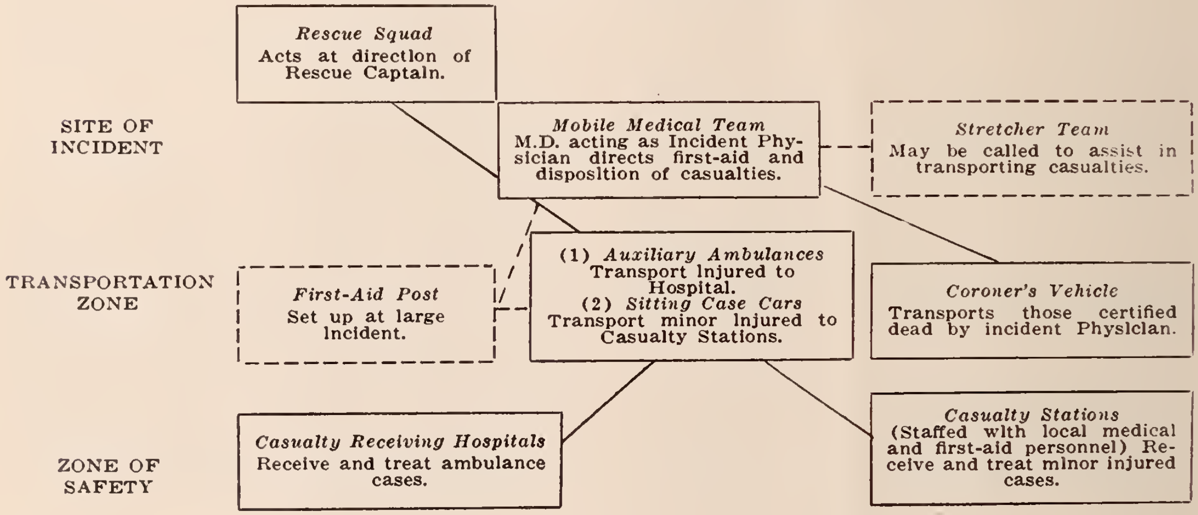
* May be 1. Separate official, 2. Local Health Officer.

TABLE 2.—*Diagram No. 2: Plan of Care of Injured*



SITE OF INCIDENT

TRANSPORTATION ZONE

ZONE OF SAFETY

Rescue Squad
Acts at direction of Rescue Captain.

Mobile Medical Team
M.D. acting as Incident Physician directs first-aid and disposition of casualties.

Stretcher Team
May be called to assist in transporting casualties.

First-Aid Post
Set up at large incident.

(1) *Auxiliary Ambulances*
Transport injured to Hospital.
(2) *Sitting Case Cars*
Transport minor injured to Casualty Stations.

Coroner's Vehicle
Transports those certified dead by incident Physician.

Casualty Receiving Hospitals
Receive and treat ambulance cases.

Casualty Stations
(Staffed with local medical and first-aid personnel) Receive and treat minor injured cases.

by the Nurse Deputy. This section also coöperates with the Public Health Department and the Red Cross in the organization of a Home-Nursing Program that provides for organized home-nursing care after an emergency.

The Health Officer should develop plans for prompt and appropriate action during and after any disaster to insure:

1. Maintenance of safe water, food, and milk supplies.
2. Sanitary disposal of sewerage and putrescible wastes.
3. Sanitation at mass-feeding centers, rest centers, casualty stations, and other temporary facilities for emergencies; and
4. Control of communicable diseases.

Since large-scale enemy action is only a slight possibility on this coast now, the maintenance of emergency control centers and the drilling of their entire personnel is no longer practicable. Each department in regular civic functions can handle its own problems in its particular manner. There should be provided, however, an information center with proper emergency communications where the chiefs of each service of the locality meet in an emergency to direct and coordinate activities. It is still recommended that drills of the Emergency Medical Service be held on the average of every six months for the Duration. The other articles in this issue outline standard emergency procedures that can be adopted in order to simplify and make more effective operations in the field and in the hospitals.

The articles presented in this symposium may serve as a guide for standardizing emergency medical operations. Each state medical, nursing, and hospital organization can better perpetuate the Emergency Medical Service by asking all communities to maintain up-to-date rosters of professional people assigned to this service, and also seeing that they continue to maintain emergency equipment and facilities in all hospitals.

3491 Pacific Avenue.

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Field Care and Transportation of the Injured.
Technical Manual for the Rescue Service.
Syllabus of Course of Instruction for Nurses' Aides.
Guide for Training of Volunteer Nurses' Aides.
Instructor's Outline for First Aid Course for Civilian Defense.
Advanced First Aid for Civilian Defense.
Treatment of Burns and Prevention of Wound Infections.
A Technical Manual on the Preservation and Transfusion of Whole Human Blood.
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BURNS*

Harry M. Blackfield, M. D.
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It is now recognized that the treatment of a severe burn should be aimed at the prevention of its two major complications, shock and infection. It is a great deal easier to prevent or treat these complications early than to relieve them after they have developed. Many types of local therapy have merit, and two of these will be discussed later. All are agreed, however, on the therapy necessary for the prevention and treatment of shock in a severe burn. The mortality which previously occurred early in severe burns has been greatly reduced by the use of adequate transfusions of plasma. It must be remembered that, though it is not always possible to carry out ideal therapy, care can and should be taken not to institute therapy which might be harmful. Few surgical conditions necessitate the wide knowledge and meticulous care that a severe burn does.

EMERGENCY CARE AND FIRST-AID TREATMENT

All patients with severe burns must receive immediate treatment for shock. They should be placed in a supine position and given an injection of morphine. At least one-half grain is necessary to alleviate the severe pain, and to help combat the shock which accompanies an extensive burn. If it is anticipated that the patient will be immediately transported to a hospital, no local therapy should be carried out except to prevent the burn from being contaminated during the period of transportation. If possible, sterile gauze should be applied to the burned area and, if this is not available, clean linen should be used and the patient covered with a blanket or some article of clothing to keep him warm.

If it appears that it will be impossible to hospitalize the patient in less than two hours, local treatment may be carried out as follows, if the materials are available. No effort is made to remove more clothing than is necessary to expose the burned surfaces. Rings should be promptly removed from the fingers of burned hands. Burned surfaces may be covered with a sterile boric ointment, petrolatum or 5 per cent sulfathiazol water-soluble jelly spread on a layer or two of fine mesh gauze (44). Large gauze dressings or sterile cotton waste is placed over these dressings and the entire dressing bandaged firmly in place. If the burn is on an extremity, a splint will simplify its handling and offer a more comfortable means of transportation. Ointments or jellies containing tannic acid are no longer recommended for the first aid treatment of burns, and should not be used. A certain proportion of burns become infected by organisms present in the skin about the burn. A still larger proportion become infected by organisms later introduced into the burned area. For this reason every effort should be made to minimize secondary contamination. With these facts in mind it is important that the patient and all attendants handling burn cases should be capped and masked if it is possible. If it is impossible to cover the burned area with sterile gauze, all efforts should be made to keep from contaminating the burned area. The injection of undiluted plasma intravenously should be instituted as soon as possible.

DEFINITIVE TREATMENT

The definitive treatment of a severe burn should be carried out as soon as the patient reaches a location where the facilities are adequate, and the patient will remain sufficiently long to receive the treatment. The first consideration, of course, is the treatment of shock. Additional morphine is usually required and the transfusion of plasma should immediately be instituted. Since every severely-burned patient will require plasma, its administration should be started immediately without waiting for laboratory reports. Those who are responsible for the treatment of extensive burns should be familiar with the Berkow method of estimating the extent of cutaneous lesions. After figuring the percentage of the body which has been burned, it is possible to estimate roughly the amount of plasma required for the patient during the first 24 hours. If the burn involves 10 per cent or more of the body surface, 50-100 c.c. of plasma should be administered for each per cent of the body surface burned. For example, a patient who has had 10 per cent of the body burned should receive 500-1000 c.c. of undiluted plasma during the first 24 hours. For those with severe burns a large amount of plasma may be necessary during the first 24 hours; this is usually given in divided doses. After the injection of plasma has been instituted, the laboratory work which can be used as a guide for the amount of additional plasma required should be done. The hemoglobin, or even more valuable, the hematocrit reading should be carried out regularly. For each point that the hematocrit rises above 45 per cent cells, at least 100 c.c. of plasma should be administered. If clinically satisfactory results are not obtained with this dosage, larger quantities should be given.

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* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

From the Department of Surgery, University of California Medical School.

Other Fluids:

Large quantities of saline and glucose should not be administered. The volume of both should not exceed the amount of plasma injected in a given period of 24 hours. In cases of severe hemo-concentration, larger quantities may be given slowly. If additional fluids are necessary, a 5 per cent solution of glucose in distilled water is preferable, as it has been shown that large amounts of neutral sodium salts, such as sodium chloride, will intensify the tendency to edema. The patient may be permitted to drink moderate amounts of water, but no food should be offered until his stomach can retain it and the shock has been overcome; then food and fluids may be given orally as desired.

When the patient is in a state of shock, with his extremities cold and his pulse weak and thready, caution must be exercised against warming him too rapidly by externally applied heat. Sudden warming of the skin in the presence of inadequate blood volume may precipitate complete circulatory collapse by dilation of the peripheral vessels.

Whole Blood Transfusions:

Transfusions of whole blood should not be given in the early treatment of a burned patient unless hemorrhage has occurred from other injury, and then only when the state of shock has been satisfactorily overcome by the use of plasma. If no plasma is available blood may be substituted. Anemia frequently develops after several days following a severe burn, and in this event, whole blood is necessary and should be administered as indicated.

Care of Burned Area

Regardless of the method of local therapy, some definite measures should be instituted to prevent additional contamination of the burned area. For this reason the surgeon and his assistants should be capped, masked and gloved. The dressing is removed carefully and the burnt area inspected. All clothing is cut away if necessary. Ether, benzine, lard or other detergents should be used to remove grease if present. With plain white soap, soft cotton and sterile water, the burned area should be cleansed gently and as thoroughly as possible. Loose epidermis and foreign material may be removed with sterile forceps and scissors. Remember that it is rarely necessary to wash a freshly burned surface. Scrub brushes, green soap and vigorous rubbing do more harm than good.

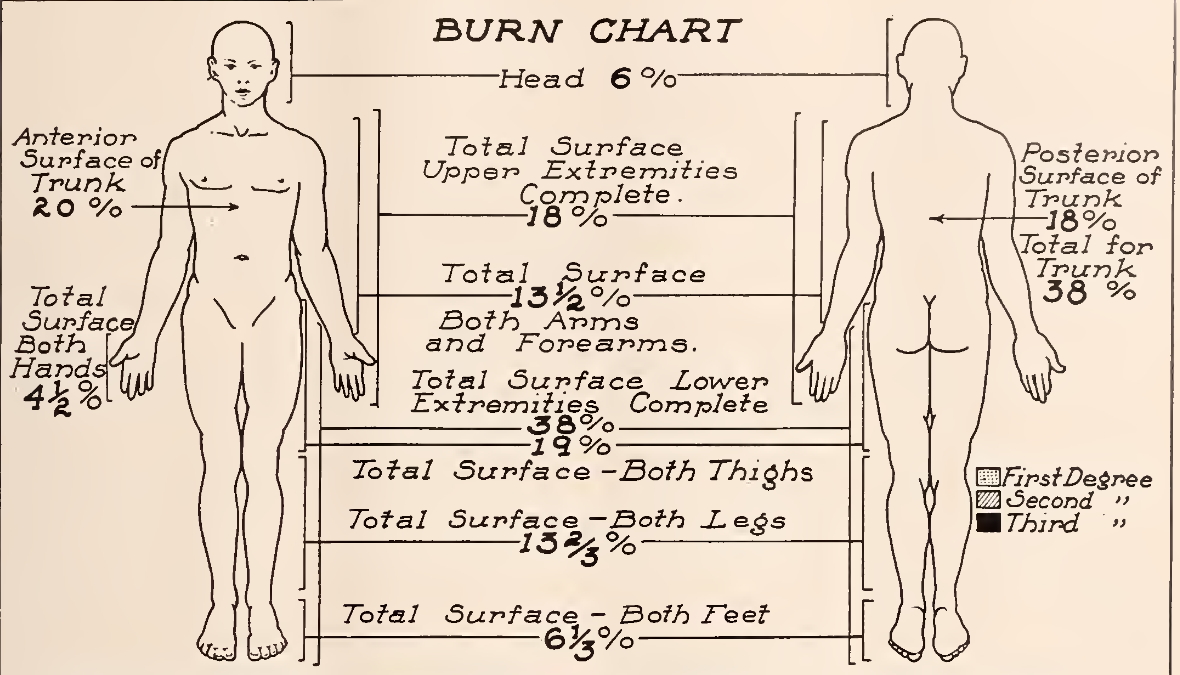
Common Types of Treatment

The Pressure Dressing Method:

Over the prepared surfaces apply gauze of fine mesh impregnated with sterile boric acid ointment, petrolatum, lanolin, 5 per cent sulfathiazol jelly or 3 per cent xeroform in petrolatum. Over this place sufficient sterile gauze or sterile cotton wadding to provide a thick layer that furnishes smooth, even compression when bandaged firmly in place. For the pressure dressing, stockinette or some type of elastic bandage is more effective than rolled gauze bandage. If an extremity is involved, start the dressing near the tips of the digits. Separate the digits, and if possible, carry the dressing well above the burned area. A splint may be added as a final step in dressing an extremity. The finger tips, if unburned, may be left exposed so that the circulation can be checked. Be very careful that sufficient pressure pads are placed over prominent bones and about the fingers. Properly applied pressure dressings may be left in place from twelve to fourteen days. At the end of that period areas of partial skin thickness loss should be healed. Areas of necrotic whole thickness loss are excised, usually followed by wet dressings. From this time on the granulating area is not treated as a burn, but as any granulating wound would be treated, and every attempt is made to clean it up as quickly as possible and to prepare it for skin grafting.

The Escharotic Method:

This method is particularly indicated in extensive flash or superficial second-degree burns of the trunk. The hands, face, feet, perineum and genitalia should never be tanned. These areas should be treated as described under the pressure method. The tanning escharotic method should never be used unless the burn can be treated immediately, and not even then if it has been grossly contaminated. When tanning is employed, one should use the method of rapid coagulation, such as the combined use of tannic acid and silver nitrate. Slow methods of tanning, such as are obtained with tannic acid jelly or tannic acid solution without silver nitrate, permit absorption of the acid with a possibility of serious toxic effects, particularly necrosis of the liver. Furthermore, many hours are required to effect an adequate tan, allowing opportunities for contamination. Two spray guns are to be available. One is to contain only the tannic acid, the second, equal parts of tannic acid and silver nitrate solution. Less pain is experienced if the tannic acid alone is applied first, followed immediately by the tannic acid-silver nitrate spray. One half hour later, and every half hour


BURN CHART
Head 6%
Anterior Surface of Trunk 20%
Total Surface Upper Extremities Complete. 18%
Posterior Surface of Trunk 18%
Total for Trunk 38%
Total Surface 13½% Both Arms and Forearms.
Total Surface Both Hands 4½%
Total Surface Lower Extremities Complete 38%
19%
Total Surface - Both Thighs
Total Surface - Both Legs 13⅔%
Total Surface - Both Feet 6⅓%
▦ First Degree
▨ Second "
■ Third "

Berkow's method of estimating the extent of surface area.

	ADULTS	CHILDREN	ESTIMATE
Head	6%	12 minus age in years plus 6	
Trunk	38%	40%	
Lower extremities	38%	38 minus (12 minus age in years)	
Upper extremities	18%	16%	
		Total	

BURN SHOCK

	Initial			12 Hrs.	1 Day	2 Days	3 Days	4 Days	5 Days	6 Days
B.P.										
Pulse Rate										
Hemoglobin (100% = 14.5 gms.)										
R.B.C.										
Hematocrit										
Plasma Proteins										
A/G. Ratio										

FLUID REPLACEMENT THERAPY (cu. cms.)

Plasma								
Whole Blood								
Saline								
Glucose								
5% Glucose in saline								
Urinary Output								
Blood Substitute								⑨

for four applications, spray with the tannic acid-silver nitrate mixture. If the tan is not then adequate, continue spraying every hour until the objective is achieved. While drying, the burned area should be left exposed to the air under a canopy, heated if the environmental temperature is low. The bed should be kept covered with sterile linen if the eschar is to be left exposed. After the eschar is dry it may be covered with sterile dressings.

If the burn is second degree, skin will regenerate beneath the tan and the latter will separate spontaneously. If the eschar remains intact for three weeks, it may be assumed that a third-degree burn has been sustained, and the eschar should be removed. It is usually necessary to carry this out under light general anesthesia.

Paraffin Wax Method:

More recently this method has been revived and modified by Doctor R. C. Pendleton at the Mare Island Naval Hospital. Many of those who have had experience with this method are enthusiastic about the ease and economy with which it can be carried out. This essayist has had no experience with the method and therefore does not feel qualified to present an opinion.

Infection Beneath Eschar:

If infection occurs beneath the tan or eschar, or the patient shows systemic or local signs of sepsis, the eschar should be carefully inspected. If an area looks suspicious a hole should be made through the eschar and, if pus is encountered, the entire area of suppuration should be unroofed by means of sterile sharp instruments. This can usually be done without much trauma and without anesthesia. The suppurating surface should then be treated by wet saline compresses, as for any infected granulating wound. Crystalline sulfanilamid may be applied over the exposed surfaces daily thereafter. If the area is large, no more than 15 grams of sulfanilamid should be used in any one 24-hour period, as toxicity may result.

Treatment of Granulating Areas:

It must be remembered that all third-degree burns result in granulating areas. These granulating areas must be effectively and rapidly cleaned up in preparation for skin grafting, if the patient is to be spared the septic stage of a burn during which anemia, cachexia and damage to kidneys and livers may occur. Recently we have learned that the process of "cleaning up" may be greatly accelerated by the daily use of a light dusting of sulfanilamid crystals and the application of compresses to the area, thus permitting the application of skin-grafts earlier than heretofore. Dressings always should be as painless as possible.

Oral Administration of Sulfonamide Drugs:

Although it has not been routinely our custom to give sulfa drugs by mouth to patients with severe burns, sulfadiazine by mouth may be administered, particularly if the definitive treatment is delayed. This drug has been chosen because it is the least toxic of the three commonly used sulfa drugs. The dosage is 1 gram every 6 hours, day and night for ten days. If sensitivity is present it may be necessary to use one of the other drugs. It is dangerous to give a sulfonamid drug to a patient who is not voiding normally over 1000 c.c. per day.

SUMMARY

1. The treatment of a severe burn should be aimed at the prevention of shock and infection.
2. The use of blood plasma in the treatment of shock has materially reduced the early mortality in severe burns. 50-100 c.c. of plasma should be administered for every per cent of the body burned.
3. Simple first aid measures may be carried out anywhere if materials are available, but definitive treatment should only be instituted where facilities are adequate.
4. Every effort should be made to minimize secondary contamination of the burn.
5. Large quantities of saline and glucose should not be administered, as they tend to intensify the edema and dilute the blood proteins.
6. Whole blood transfusions should not be used in the early-burn treatment, unless hemorrhage has occurred, or plasma is not available. Later, when anemia appears, blood transfusions are indicated.
7. Strong antiseptics or vigorous scrubbing should never be used on a burn. Plain white soap, cotton and sterile water will cleanse the area adequately.
8. The two most commonly-used methods of local therapy are the pressure dressing method and the tannic-acid and silver nitrate escharotic method.
9. All third degree burns result in granulating areas. These areas should be cleaned up as rapidly as possible in preparation for skin grafting.
10. Sulfadiazine may be administered orally to severe burns, particularly if proper therapy cannot be instituted early.

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CRUSH SYNDROME

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Crush syndrome was recognized clinically during the last war, but little literature was devoted to it then. It has since then, for a time, been dropped entirely from the literature of medicine. Within recent years reports have again appeared, mostly in British literature, concerning this syndrome. Most of the reported cases have been victims of bombing attacks who had been imprisoned beneath heavy débris and suffered prolonged crushing injury to a mass of muscle tissue.

The individual who has been pinned beneath fallen débris for a period of time in such a way as to have a mass of muscle tissue crushed, and its vascular supply injured, is subject to this syndrome. He may or may not show vascular shock at the time he is extricated. The presence or absence of primary shock should not in any way lead one away from being on guard against the crush syndrome. The crush syndrome may appear at any time from two to forty-eight hours following release from the compression. Crush syndrome is a toxic condition of the kidneys resulting from the absorption of broken-down muscle proteins following sudden release from pressure. It is characterized by the classical symptoms of destruction of the kidney, and its failure to perform its function of secretion. All symptoms of kidney failure appear, and death results from kidney failure.

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* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

The person giving first aid should recognize the probability of crush syndrome from the position in which he finds the victim. He should, as far as he is able, prevent the absorption of muscle protein into the circulation by the application of a tourniquet. He should then note, on the identification tag, the history of a crushing and compression muscle injury. That the victim does not show any symptom of vascular shock should be no excuse for failure to apply a tourniquet, or to make the notation on his identification tag.

This history of a sustained crushing injury is of the utmost importance to the attending physician at the receiving hospital. Regardless of primary shock, the attending physician should take all precautions against the possibility of the appearance of the crush syndrome, recalling that it is a toxic condition of the kidney resulting from rapid absorption of toxins from the ischemic crushed muscle. By the use of the tourniquet in applying intermittent pressure, he should restore the blood supply and retard the absorption of the toxin.

Primary shock should be dealt with promptly by injecting plasma. Blood pressure and blood volume should be restored. The victim who may be subject to crush syndrome will stand a far better chance of recovery if all primary shock has been cared for adequately.

When the peripheral arterial pulse has disappeared, multiple incision into the tense edmatous tissues may be indicated as a means of saving the limb. Early amputation should be done when it becomes evident that the circulation cannot be reëstablished. The patient may have injuries apart from the crushing of muscle tissue, and which may require special attention. We may help to prevent secondary shock by giving morphine for relief of pain, by splinting fractures and controlling hemorrhage.

Whether surgery has been performed or not, whether primary vascular shock has been present or not, the victim should be watched and treated with the awareness of the possibility of crush syndrome. The syndrome may begin to appear within a few hours after admission to the hospital or at any time within forty-eight hours. The rising acidity of the urine, with its typical red tinged casts and albumin, and the rising blood pressure, and the closing down of urinary secretion are indicative of kidney involvement.

Preventative measures should be begun promptly. Alkalinization of the urine is important. Alkalis should be given until the urine remains alkaline to litmus. Methyl red should be used, however, to detect the degree of acidity. If the urine cannot be made alkaline to methyl red, the prognosis is grave. Intravenous alkalies may be necessary to maintain an alkaline urine. Five per cent sodium bicarbonate solution intravenously, as used in the last war, may be employed in order to maintain an alkaline urine.

Fluids should be given for the purpose of maintaining the water balance of the body, that it may offer sufficient water for dilution of the muscle toxin in the secretion by the kidney, but not enough that it may cause edema of the crushed muscle.

Normal saline or dilute glucose (5 per cent solution) are contraindicated because, in the presence of a highly acid urine, either will tend to cause edema. A hypertonic solution of 2 per cent magnesium sulphate or 15 to 20 per cent glucose solution are to be preferred for their dehydrating effect on the swollen kidney. The kidney, swelling within its capsule, tends to compress its own blood supply, thereby doing additional damage to that already present. Solutions given should tend to prevent edema of the kidney.

Plasma should be given with the idea of sustaining the blood volume. Too much plasma, especially when the blood pressure is normal or is beginning to rise from damage to the kidneys, may be dangerous in that it will hold the water against kidney excretion.

The blood chemistry of the crush syndrome shows at its very beginning a rise in the N.P.N., and frequent laboratory checks of the N.P.N. may greatly help in the detection of an oncoming crush syndrome.

COMMENT

With a stepping up of bombing incidents, we would expect more crushing injuries among the civilian population, and an increase in the number of cases presenting the crush syndrome. Such injured person should be carefully watched, and shock and kidney damage should be forestalled. If evidences of beginning shock or kidney damage appear, antishock treatment should be instituted promptly and the kidneys protected against damage by retarding entrance of toxins into the blood by use of a tourniquet, by alkalization, and by giving fluids to maintain water balance.

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CHEMICAL WARFARE AGENTS: CASUALTIES THEREFROM*

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THE agents which have been used in chemical warfare may be separated into a half-dozen groups, according to their effects on the body. Of these, lacrimators and sternutators require little or no medical care because of the short duration of their action; while serious, the main systemic poisons cause syndromes with which physicians have become familiar in civil practice. Moreover, tacticians do not expect the enemy to use lacrimators, sternutators or systemic poisons against civilians in this country.

If the enemy comes, however, he may be expected to bring incendiaries, lung irritants and vesicants. A knowledge of the general aspects of chemical casualties due to these agents is of the utmost potential importance.

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* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

From the Department of Medicine, Stanford University Medical School. This work is based on Civilian Defense publications.

1. *Lacrimators:*

The chief action of tear gases is a prompt but transient irritation of the eyes, with lacrimation, photophobia and blepharospasm. Leaving the gassed area, the victim may obtain relief on facing windward with open eyes, which should not be rubbed. The need for medical attention is small; therapy consists of irrigation with warm saline or freshly-prepared 2 per cent solution of sodium bicarbonate. Later, sterile glycerine or boric acid ointment may be used.

2. *Sternutators:*

These agents cause a longer lasting irritation of the upper airway and paranasal sinuses, with vomiting, sneezing, and violent headache leading to mental depression. Sedatives, acetyl salicylic acid or related analgesics, and assurance of an early recovery are of prime importance. The nares may be sprayed with saline, 2 per cent solution of sodium bicarbonate or the following:

Neosynephrine hydrochloride 1%....	4.
Pontocaine hydrochloride	.04
Boric acid saturated solution........	12.

3. *Systemic Poisons:*

(a) Hydrocyanic acid poisoning is treated by artificial respiration and intravenous injections of methylene blue (50 cc. of 1 per cent methylene blue is isotonic solution).

(b) Arsine causes an acute hemolytic anemia, treated directly by transfusions of whole blood or red cell mass and inhalations of oxygen. Sodium bicarbonate in large doses by mouth may prevent precipitation of hemoglobin in the renal tubules with consequent uremia; for the same reason, urine output is to be maintained at a high level by the use of oral and parenteral fluids.

(c) Carbon monoxide is formed during explosions and settles into bomb craters; treatment includes artificial respiration with inhalation of oxygen and carbon dioxide, transfusions of whole blood or red cell mass, and measures against shock.

4. *Incendiaries:*

Therapy of thermal burns must be directed not only to the local wound, but with extensive injuries to the individual as well.

In this restricted space, it is not possible to discuss the features of the many methods advocated for local treatment of burns. Most agree that greases and oils are to be avoided as first aid measures, but from there on the physician has a wide latitude of choice. For minor burns, sterile vaseline, triple dye, or a sulfonamide in aqueous jelly have been recommended. For more severe injuries, one of the best methods is that of pressure dressings with sulfathiazole or boric acid ointment; sodium sulfadiazine may be given intravenously to combat infection, while tetanus antitoxin may be used if indicated. Full aseptic technique should be carried out while dressing burns.

With severe burns, shock is present; its management is outlined in an accompanying discussion, with the notation here that, since hemorrhage is absent, plasma is preferable to whole blood.

Once past the immediate dangers, attention must still be given to both local lesions and the patient himself. Skin grafts and the prevention and treatment of contractures are in order. Hypoproteinemia and a state of general malnutrition may supervene unless care is taken to insure an abundant intake of food with particular emphasis on protein; of the vitamins, thiamin and ascorbic acid are most useful.

During war, thermal burns may be inflicted upon civilians fighting fires started by incendiary bombs; these contain white phosphorus. Wounds in which particles of phosphorus are present should be flooded with water at once, and the phosphorus removed while the wound is under water. A 2 per cent solution of copper sulfate is said to be helpful by the formation of an insoluble coating of copper phosphide. In further local treatment one proceeds as with thermal burns; escharotics are contraindicated. Bits of phosphorus in the eye are to be washed out immediately with water, following which 0.5 per cent pontocaine ointment and a dressing may be applied.

5. *Pulmonary Irritants:*

Chlorine and phosgene produce pulmonary edema, necrosis of tissue and thrombosis of the small pulmonary vessels. After a slight reflex irritation, which may or may not occur at the moment of exposure, there follows a latent period during which the development of lesions is silently taking place. The first symptom is restlessness, followed by a vague sensation of oppression. Anoxemia soon leads to cyanosis, and accumulation of carbon dioxide adds to dyspnea. By this time, cardiac and respiratory rates are rapid, râles appear, coughing produces watery sputum, and the neck veins are full; shock occurs much later, bronchopneumonia may complicate the picture. If the patient recovers, pulmonary fibrosis or other complications are very rare; statistics show no increase in pulmonary tuberculosis in those gassed by lung irritants in World War I.

Treatment is directed at anoxia and dyspnea, shock, and complicating infection. Once symptoms appear, complete rest is essential; this reduces blood flow through the throttled pulmonary vascular tree and decreases the need for respiratory movements. It is no longer thought that bodily activity need be stopped at the moment of exposure. For the respiratory symptoms, injections of morphine and atropine, and inhalations of oxygen without carbon dioxide are most useful; intravenous injection of aminophyllin has been recommended in addition. Artificial respiration is contraindicated. Because of the distended jugular veins with dyspnea, there may be a temptation to remove blood; this should not be done, for shock is present or impending. Furthermore, the pulmonary lesions modify measures against shock, in that plasma must be given cautiously and the head-down position may embarrass respiration.

The immediate danger is over after 48 hours, when the pulmonary lesions may be complicated by pneumonia; sulfonamides should be given as one would for lobar pneumonia.

If a wound necessitates operation under anesthesia in a patient injured by a pulmonary irritant, inhalation and spinal methods should be replaced by field block or local anesthesia.

6. *Vesicants:*

The main action of the mustard "gases" and of Lewisite is the production of severe inflammation of skin and eyes. Prevention of this effect by energetic first aid or, better, self help is of utmost importance.

Since one has only a few minutes to remove or neutralize these agents, *speed* in carrying out a predetermined plan is essential. Remove the victim from the contaminated area and his clothes from him. If exposure to the liquid form of the mustard or Lewisite has occurred within five minutes, wash the eyes thoroughly with freshly prepared 2 per cent solution of sodium bicarbonate (heaping tablespoonful per quart of *warm* water) if available at once; tap water is preferable in case of delay. In the event of exposure to vapor, or to liquid vesicant prior to five minutes, lavage of the eyes is useless and may even be dangerous. Next, blot without rubbing any excess vesicant from the skin, disposing of the used absorbent cotton or toilet tissue to prevent other burns.

Neutralization of the agent follows. Logically, one should identify the vesicant in order to select the best neutralizing substance. This takes time, and, after all, neutralization is only one step in the prevention of lesions. Household bleaching solutions (clorox or purex) of hypochlorite are effective at least against mustard (alone or mixed); pat on the contaminated skin surfaces, but do not use on the eyes.

Finally, and most important, wash carefully in a shower with plenty of lather and water. Dry without rubbing, and clothe.

To summarize self help: (1) remove the victim from the gassed area and his clothes from him, (2) wash the eyes (if very recently exposed to liquid vesicant) with water or fresh weak sodium bicarbonate solution, (3) blot off excess vesicant, (4) neutralize with household bleaching solution, and (5) shower with abundant lather and water.

The directions given above should be memorized by all civilians for their own use, and may be carried out by physicians working in decontamination stations.

Once the vesicant has injured the skin, the patient and his wounds are treated as for thermal burns. Hypochlorite is not used after erythema appears; blisters need not be opened to remove hypothetical toxic agents. No oil, neutralizing agent or tight bandage should ever be applied to affected eyes; for pain, 0.5 per cent pontocaine (not cocaine) solution is helpful, and 1 per cent atropine should be used against miosis. Photophobia requires dark glasses. Later, boric acid ointment or sulfathiazole ophthalmic ointment may prevent or treat secondary infection.

Clay and Webster Streets.

WOUNDS: THEIR CARE UNDER CIVILIAN DEFENSE*

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Wounds obtained under conditions of bombing, explosions and gunfire vary from abrasions to severe contusions, with at times great tearing and rupture of tissues and shattering of bones. It is important, therefore, that each responsible physician be informed as to the nature of these injuries, and have a well thought-out plan how he will proceed promptly, and in an orderly manner, to render the best care possible under any given circumstance.

Wounds will, therefore, be discussed under the headings: their nature, the rôle of devitalized tissue, bacteriology and treatment.

NATURE OF WOUNDS

Abrasions are no different than those of civil injury, except possibly for greater contamination.

Wounds of the soft tissues, due to great and sudden forces or to a crush from falling timbers or walls, have a more widely-distributed injury. There is also the chance of greater contamination due to such a high proportion of wounds being caused by secondary objects as glass, wood, masonry, etc. This leads to devitalization of tissue upon which microörganisms may live and develop, or to rupture of blood vessels with hemorrhage, furnishing thereby a nidus for infection. *The devitalization of tissue and contamination are the factors of primary importance.*

The contamination of wounds, under conditions associated with civilian defense in a war zone, forces us to consider wounds in their two main stages—that of contamination and that of infection. Contamination is that stage where the bacteria are upon the surface and not as yet proliferative; whereas infection is the stage where bacteria have invaded the tissues and proliferation is occurring.

The stage of contamination may exist up to twelve hours, but preferably should be considered up to six or eight hours. The degree of contamination varies, dependent upon the location in or out of a building, a heavily-cultivated soil, a sandy loam or paved street, the condition of the weather giving a dry warm dust or a muddy contamination of objects and clothing; the portion of the body involved, for example, the clostridia are more common about the lower extremities, especially the thigh; and the type of cleanliness of the clothing worn and the cleanliness of the individual, for example, the clostridia are found in a high percentage of instances to be present in woolen garments, and recent bathing gives less infection.

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* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.
From the Woodland Clinic.

The stage of infection or invasion of the tissues follows that of contamination. It is dependent upon the pathogenicity and virulence of invading microörganisms; upon the degree of local trauma, that is, the amount of devitalized tissue; the presence or absence of foreign material acting as a carrier; and the resistance of the patient locally and constitutionally.

THE RÔLE OF DEVITALIZED TISSUE

The rôle of devitalized tissue in bacterial contamination and infection was emphasized during the last great war as it never was before. *The observance of this phenomenon is the most important aspect in the care of traumatic wounds.* A vital tissue will resist infection in varying degrees, but a piece of dead tissue serves as an excellent medium upon which all types of microörganisms, especially the clostridia, thrive. A scalpel wound has only a microscopic injury to tissue, a machine gun or rifle bullet has a comparative high velocity and a sharp and narrow striking force, and so causes little comparative tissue damage; but an irregular shell fragment with a slower velocity has a greater striking force, and causes a wider tissue damage.

The foreign body acts mainly as a vehicle of infection, but plays an important part in sustaining the infection. Bits of clothing or contaminated terrain are the most evil, and serve as carriers of infection.

The patient's resistance, both local and general, has to be reckoned with the same as in peacetime surgery. The general resistance is lowered in instances of hemorrhage, exhaustion from physical fatigue, or exposure or sepsis. The local resistance is obviously dependent upon the nourishment of the injured portion of the body and its blood supply. The greater the trauma, there results a greater contusion of tissue, a greater amount of extravasated blood, a wider dispersion into the tissues of extraneous material, and a larger area deprived of an adequate blood supply. An impoverished blood supply leads to tissue of poor vitality, an ideal culture medium, and an easy invasion by bacteria.

BACTERIOLOGY

The most common bacteria in civil traumatic wounds are the staphylococci and streptococci, and the spore-bearing anaerobes, Clostridium tetani, Clostridium welchii and Clostridium septique. Severe traumatizing injuries of peacetime demonstrate that these anaerobes are present everywhere, in our woolen clothes, in our school yards, on walls of our buildings, and in our yards, gardens, streets and highways.

Fifteen per cent of all wounds culture streptococci in the first twelve hours, while in a few days the percentage is much larger—90 per cent. Meleney, from a study of peacetime acute traumatic wounds, finds, in 200 such wounds, bacteria present in every instance; states no one can tell which wound will develop an infection, and that hemolytic streptococci were present in the stage of contamination in 17 per cent of instances.

The source of this infection is from the soil, from the contaminated soiled clothing, and from the unapparent slips of technique in wound dressings, and from the nasopharynx of individuals in contact with the wound. Hare stresses the last source especially, and states that 7 per cent of normal people are nasopharyngeal carriers of the important strain—hemolyticus streptococcus pyognes, (streptococcus pyogenes of Rosenbach.)

The anaerobic spore-bearing bacteria are found in wounds in all tissues, but it is chiefly in muscle that we see their complication—"gas gangrene"—develop. Quist divides the clinical evidence of these causative organisms into three groups: "(1) harmless saprophytes in ulcers with no pathogenicity, (2) pathogenic microörganisms producing an infection of the cellular connective tissues; gas infection of a wound or anaerobic cellulitis and, (3) as invaders of muscle-true 'gas gangrene'."

The anaerobic cellulitis or local wound manifestation is seen in subcutaneous tissue. Here occurs some devitalization of tissue, hematomata and the bacteria proliferate. There may be some extension of the products of the gas-forming microörganism to give local swelling and crepitus to some distance from the abscess; but this form of the disease, while it can go on to more extensive involvement and toxemia, usually promptly subsides with adequate drainage and removal of pabulum on which the microörganism develops.

True, "gas gangrene" is an acute, spreading gangrene, with gas formation and muscle involvement. It is not the muscle involvement alone that is essential, but an additional factor of the greatest importance is the confinement to limited space—*tension.* The disturbance of the blood supply is the important antecedent to proliferation of the infection. If a foreign body with microörganisms penetrates through a small opening and grossly injures the muscle without disturbing the overlying fat, skin and fascia, there is present the ideal condition for their development—namely, devitalized tissue, freedom from oxygen and an enclosed area for increased local tension within constricting fascial tissues, so that blood supply can be impaired to point of destruction. As a result, one sees involvement of a single muscle or of a group of muscles or an extremity as a whole. Some muscles, as the gracilis, are believed to have a limited and terminal blood supply, and are especially prone to development of "gas gangrene."

The destructive process in the muscle primarily increases intrafascial tension from gas and fluids, a strangulation of the blood supply by compression, and a probable injury to the blood vessel wall by the toxin, and therewith a resulting de-

Table 1.—*An Orderly Plan for Care of Traumatic Wounds.*

I.—At Dressing Station

Direct (wound)	Indirect (injured person)
A. First importance	1. Avoidance of shock.
1. Sterile dressing properly bandaged.	2. Proper hemostasis (pressure bandage over wound rather than tourniquet recommended.)
2. Immobilization.	3. Anodyne for rest.
3. Careful notation on card as to wound and complications.	4. Serum or fluids if necessary.
B. Second importance.	5. As little moving as possible.
1. Washing of wound with sterile solution (ear syringe.)	6. Exclusion of relatives and friends.
2. Application of sulphonamide or antiseptic.	

* * *

C. Disposal of the injured persons.

1. Patients with minor wounds: Dressed and advised where and when to return.
2. Patients with major wounds: Moved within six hours carefully to base hospital.

* * *

II.—At Base Hospital

Direct (wound)	Indirect (injured person)
1. Careful investigation of nature of wound and complications, if any.	1. Orderly progress of patient with least disturbance from entry to proper place of care.
2. X-ray if necessary.	2. Complete record of data.
3. Cleansing and shaving of skin.	3. Choice of anesthesia.
4. Debridement.	4. Fluids, sera or blood transfusion as necessary.
a. Washing.	5. Avoidance or treatment for shock.
b. Careful excision.	6. Adequate sedation.
c. Change of instruments.	7. Rest from relatives and friends.
d. Suture without tension.	
5. Immobilization.	
6. Sulphonamides in wound.	
7. Serotherapy for anaerobes.	
8. Elevation and rest.	
9. As infrequent dressings as possible.	

generation of the muscle fibers. Bloodstream invasion of the microörganisms in any dangerous degree is not thought to occur until there is an overwhelming local infection. In the terminal stage a severe toxemia develops, and because of a hemolytic effect from the toxins, a jaundice frequently occurs.

TREATMENT

The time element, the stages of contamination and of infection respectively, have already been stressed. The endeavor must always be to care for the wound properly and adequately in the stage of contamination. That is preferably within six hours. Again, since devitalized tissue, hematomata and débris are the factors that can be removed to eliminate infection, it is important to care for these in the early stage. This means surgery. Almost every traumatic flesh wound demands surgery. This surgery is debridement, as we in America use the term, or "complete excision" as many English authors choose to say. Previous to doing a debridement, a careful history of conditions of the injury, the position of the extremity, the tissue traversed by the missile, and a careful physical examination of circulatory, nerve and muscle function, are important and should be recorded. An x-ray plate is always wise.

Debridement properly done is an art. "Judgment is the prime requisite." Gentleness in handling of tissues and meticulous thoroughness of the removal of all devitalized tissue and foreign material, and care to hemostasis, are the second requisite. Originally, and still in the deeper wound recesses, curved scissors were the cutting instrument most adaptable. However, if knife-blade severance into live tissue can be made, it is to be preferred. Sponging should be of the blotting, not wiping type. Flex and extend the extremity in order to reproduce the exact position as when the wound was caused, and the path of the missile will be more easily followed. The skin is treated as conservatively as possible, but opened sufficiently always in the longitudinal, not transverse direction, to adequately expose all pockets, and recesses and devitalized tissue. The subcutaneous tissue needs removal of only the contaminated part. Fascial planes must be given special attention to prevent postoperative, valve-like action, (Pirogoff's Pouch). Therefore, eliptical incision, or adequate transverse incision of 1 to 2 cm. of the fascia, should be done in order to insure free drainage. The most important tissue. the muscle, is now attacked, and the meticulous care to this layer above all others spells success or failure. All muscle, lacking the normal red-to-pink color, failure to contract when pinched, or to bleed when cut, is excised to the point of absolute vitality. This may mean at times removal of an entire muscle, or a group of muscles or even an amputation. Trueta put it briefly and strongly when he said: "To be conservative with the limb is to be radical with the tissues," and we add especially muscle. Bone, loose and devoid of blood supply, should be removed. Soiled bone should be rongeured away or thoroughly washed, or at least cleansed with some antiseptic, and for this ether, an excellent fat solvent, we like best. Thorough search for bone fragments, driven to some distance from the path of the missile, is necessary. All foreign material is, of course, removed.

One must never forget that a hematoma or blood clot can serve equally well, as devitalized muscle, as a nidus of infection and so, lastly, careful attention must be given to hemostasis.

Washing and washing of a wound with sterile water or salt solution or a bland antiseptic, where contaminated tissues cannot be sacrificed, is a measure of greatest value. One may use a continuous stream from an elevated reservoir or in smaller wounds a bulb "ear" syringe serves adequately.

For traumatic wounds, debridement, already discussed, is the most important aspect of treatment. Rest is second in importance, and the use of some antiseptic, acting as the name signifies or at least as an inhibitor of the growth of microörganisms, is third. Specific antitoxin for the anaerobes is recommended.

Rest of the injured area is very important and often neglected. It is important, for movement ruptures the capillary and lymphatic thrombi by which the wound is isolated from the general circulation, and disturbs the cellular-healing processes. It must be done in such a manner, also, as to allow continuously an adequate circulation. Immobilization in bed or by splinting is often wise. Elevation of the extremity to aid blood and lymphatic circulation is beneficial.

The use of an antiseptic locally is no doubt of some value, but too heavy dependence on this should not be made. Today the sulphonamides are the popular drug, and in fresh wounds seem to have a bacteriostatic effect. A "lag period" of proliferation of bacteria, of five to six hours, is thought to occur. Therefore, in both fresh and in postoperative wounds their use is recommended.

As to whether primary suture, after debridement, is to be done, or whether the wound will be dressed open, is dependent upon the time and conditions under which the surgery is done. If the wound is cared for within six hours and can be properly debrided, and the patient can be kept under direct and continuous observation, certainly it is, as a rule, advisable and proper. If so done, suturing without tension should be stressed. However, if there is doubt as to the elimination of all infection, or the patient cannot be kept under observation, then the wound should be dressed open. It matters little if one uses sterile plain gauze, or an antiseptic and gauze, or any chemically-impregnated gauze for the wound dressing. Each physician has arrived, from experience, at his own conclusion, and one is as good as another.

Serotherapy, for the "gas gangrene" anaerobes, has proved its value, and we speak from personal observation and experience as well as from authentic reports in medical literature. A polyvalent anaerobic antitoxin from Clostridium welchii, 10,000 units, and Clostridium vibrion septique, 10,000 units, in the therapeutic dosage according to the clinical response, is of definite value, both, we believe, prophylactically as well as curatively. We recommend that where gas gangrene is anticipated, a therapeutic dose of gas gangrene antitoxin be given as prophylaxis, and be so given as to provide a continued source of supply for absorption by the body, namely, 50 per cent, intramuscularly, and 50 per cent subcutaneously. For treatment purposes it should be given in adequate dosage, for the reaction is on a quantitative basis. The need of treatment is judged by the pulse rate and patients' reactions generally, as well as by the local involvement. Some believe it of added value if injected locally near the wound; although theoretically, since it acts through the circulation, it would not seem to be of any material consequence.

The orderly plan of care of traumatic wounds, occurring as visualized under civilian defense, is therefore recommended as follows:

A wound dressing of sterile gauze or antisepticized gauge or sulphonamide and gauze, should be applied at the primary dressing station or by the first aid man. Adequate immobilization should be obtained. The patient should be transferred to the base hospital where the main care is to be given preferably within six hours.

At the base hospital a thorough debridement should be done, with primary closure when advisable, and always immobilization to the injured area and elevation if indicated. If the wound postoperatively is to be dressed open, it should not be uncovered more often than absolutely necessary.

Such is the case of traumatic wounds; yet, as a final word in the care of an injured individual, let it be remembered always *the patient comes first, the wound second.*

Woodland Clinic.

HEAD AND BLAST INJURIES*

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It has been estimated that, in the bombing of cities in Great Britain, 25 per cent of all hospital entries suffered from head injuries. Therefore, the proper care for these cases cannot be overemphasized.

Two conditions are met with: those head injuries resulting from direct trauma due to flying glass, falling débris, bomb fragments, etc., and those due to blast injuries.

First aid treatment of these cases should record:

1. The presence and degree of shock.
2. The nature of the head wound.
3. The period of unconsciousness.
4. The presence of localizing signs.
5. The presence of other injuries.

All patients suffering from head injuries must be carefully observed for the early signs of shock, and the proper treatment immediately instituted.

Scalp Wounds:

Contusions of the scalp (not associated with laceration) and hematomata require no surgical treatment. Occasionally the edge of a hematoma will be rather firm and the center soft. This is often mistaken for a depressed fracture. However, the differential diagnosis is easily made by keeping firm pressure with the index finger on the edge for about ten seconds. If it is a hematoma, the edge will quickly give way. If a depressed fracture is present, the sharp edge will remain.

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* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

Short, superficial lacerations which do not extend through the entire thickness of the scalp, only require shaving a small area about the wound, removal of any foreign body, application of some antiseptic, dusting with one of the sulfa drugs, and dressing.

At first aid or emergency stations treatment of the long lacerations and avulsions of the scalp should consist only in controlling hemorrhage and preventing contamination. The hair is clipped or cut from about the laceration, sulfanilamide (up to 5 grams) dusted into the wound, and a pressure dressing applied. At times it may be necessary to take a few sutures through the scalp to stop bleeding. No attempt is made to catch and tie bleeders in the scalp unless one of the main arteries has been severed. Careful preparation of the wound should be reserved until the patient has been brought into a fully-equipped hospital where complete examination, including x-ray studies, may be made, and where the proper facilities are available for taking care of all surgical complications existing underneath the wound.

Period of Unconsciousness:

It is extremely important that the state of consciousness or unconsciousness of the patient be recorded as early as possible. The period of unconsciousness is one of the best indications of the severity of a brain injury. Increasing stupor should suggest cerebral compression from intracranial bleeding. One point, which cannot be overemphasized, is the position of the comatose patient. He should be turned on his side so that he will not obstruct his air passages by secretions, vomitus, or by his tongue.

Presence of Localizing Signs:

Early and rather frequent neurological examinations are extremely important, and should be recorded, together with the time of observation. A detailed examination is not necessary. It can be done in a relatively short time without adding in any way to the shock of the patient. The most important points to determine are the evidence of head trauma (hematomata and lacerations of the scalp, depressed fractures, bleeding or escape of cerebro-spinal fluid from ears, nose, or mouth, etc.), the size, shape, and reaction of the pupils, the presence of muscle weakness or paralysis, and reflex changes.

Dilated, fixed pupils are associated with a very poor prognosis. A dilated, fixed pupil, providing the pupils at first were equal and reacted, is very suggestive of hemorrhage, either subdural or extradural. A mydriatic should never be used, as it is far more important to observe changes in the pupils than to look for signs of choked discs.

Muscle weakness or paralysis occurring immediately is the result of cerebral contusion or laceration. When it develops, after a period of time, one must consider the probability of a space-consuming hemorrhage. It is only by doing rather frequent neurological examinations that a progressing lesion will be recognized.

Presence of Other Injuries:

Head injuries, especially in bombing raids, are often associated with other injuries; and patients must be examined carefully as well for trauma to the spine, chest, abdomen, and extremities.

Treatment:

Of prime importance in the treatment of head injuries, after shock has been combated, is frequent observation of temperature, pulse, respirations, and blood pressure for signs of increasing intracranial pressure, frequent neurological examinations, and careful nursing. In fact, skillful nursing is one of the essentials in treatment of these cases, and, without it, many patients will not recover.

In the presence of large lacerations, compound fractures, or escape of cerebro-spinal fluid from ears, nose, or mouth, large doses of one of the sulfa drugs should be administered.

Many of these cases are irrational, restless, thrashing about, and extremely difficult to manage. Restraints are contraindicated. In fact, very often after the removal of such, the patient will immediately quiet down. Sideboards, as a rule, will prevent patient, from falling out of bed. Fairly large doses of phenobarbital, chloral, or paraldehyde will usually quiet them. The use of morphine as a respiratory depressant is ordinarily not advisable in head injuries. However, in rare instances it may be necessary to use this drug, when there is extreme restlessness not controlled by the usual sedatives, and in those cases in which the head trauma is associated with other injuries.

There is no fast rule in regard to the amount of fluids to be given in acute head injuries. Under ordinary circumstances the fluid intake in the first twenty-four hours is limited to 1500 c.c. However, this does not hold when a patient is in shock, has lost a great deal of fluids, has a high temperature, or has sustained other injuries.

The signs of increasing intracranial pressure are slowing of pulse and respirations, rise in blood pressure, or widening of pulse pressure, and progressing stupor. This is due either to a space-consuming hemorrhage or brain edema. The former requires surgery. The latter is relieved by limiting fluid intake, hypertonic solutions, or spinal puncture with drainage.

Lumbar puncture is often valuable both as a diagnostic and therapeutic measure. The amount of blood in the spinal fluid determines to a large extent the degree of cerebral contusion or lacerations, and aids in the prognosis. The measurement of the pressure is indicative of the degree of cerebral compression. Likewise, withdrawal of spinal fluid often results in marked improvement in the patient's condition.

A certain percentage of these head injuries will require surgery. Although it is not the purpose of this paper to discuss in detail operative procedures a few definite principals are enumerated.

Preparation of Field:

The wound is filled with sterile gauze, the hair

TABLE 1.—*Differential Diagnosis Points*

	Contusion Laceration	Extradural Hemorrhage	Chronic Subdural Hematoma
Unconsciousness	Immediate.	Stupor coming on after a latent period. If initial injury, severe latent period may be absent.	Latent period varies from few weeks to many months.
Temperature	Fall at first due to shock. Rise, following, depending on severity. When above 104 degrees, recovery rare.	No rise.	No rise.
Pulse and Respirations	Rapid in shock. Slow in medullary involvement. Rapid in medullary failure.	Slow.	Slow.
Blood Pressure or Pulse Pressure	Increase with medullary involvement.	Increased.	No increase.
Spinal Fluid	Contains blood — amount depends on severity. Pressure varies.	No blood unless contusion or laceration present. Pressure increased.	Either slightly blood tinged, xanthochromic or clear. Pressure varies.
Neurological Findings			
(a) Weakness or paralysis	Immediate.	Late and progressive.	Gradual and progressive. Occasionally on same side as hemorrhage.
(b) Pupils	Often dilated on side of lesion. Dilated and fixed prognosis poor.	Dilated, as a rule, on side of hemorrhage.	Often dilated on side of hemorrhage.
(c) Ophthalmoscopic	Negative first 24 hours, at least.	Negative.	Bilateral choked discs occasionally present; greater on side of hemorrhage.
X-ray Findngs	Fracture may or may not be present.	Fracture line crossing middle meningeal groove usually present.	Usually no fracture. Pineal shifted.

clipped and shaved from a large area about the laceration, and the field is scrubbed with soap, and irrigated with sterile water. Fresh sterile gauze is then replaced in the wound, the area painted with an antiseptic, and draped. The most convenient and best draping is moist towels rung out of bichloride of mercury (1 to 1000).

Anesthesia:

Operation on these patients is best carried out under either local anesthesia, novocaine 1 per cent solution with 3 drops of adrenalin (1 to 1000), to the ounce, or pentothal sodium intravenously. If the latter is used, one must give the initial injection slowly, and have oxygen ready in case there is any respiratory embarrassment.

Operation:

Scalp wounds should be thoroughly debrided and enlarged, if necessary to obtain adequate exposure of any underlying pathology. All foreign material should be carefully removed. Depressed fractures should be elevated or removed. An intact dura should not be opened unless a subdural hemorrhage is suspected. Dural tears should be debrided. All devitalized brain tissue should be removed by irrigation and suction. Superficial foreign bodies imbedded in the brain should be removed, providing their removal does not result in further damage to important areas. The wound, before being closed, should be dusted with either sulfadiazine or sulfanilamide. If drainage is indicated, it should be done through a stab wound.

Extradural Hemorrhage:

These hemorrhages usually occur within the first twenty-four hours, and demand immediate operation. The typical history is loss of consciousness immediately following the accident due to the concussion, a varying period of consciousness followed by increasing stupor, signs of increased intracranial pressure—usually some motor paresis,—and a dilated fixed pupil on the side of the hemorrhage. Treatment is subtemporal decompression, evacuation of the clot, and ligation of the middle meningeal artery.

Subdural Hematoma:

Subdural hemorrhages may be either acute or chronic. The acute subdural hemorrhages are usually associated with a laceration and contusion of the brain. Operation on these cases is sometimes helpful. The chronic subdural hemorrhages follow apparently minor head injuries, cause symptoms from one to several weeks to even months after the accident. The symptoms are those associated with chronic increased intracranial pressure, namely, headache, nausea and vomiting, visual disturbances, increasing stupor, etc.

Frequently, in these cases, the neurological examination is negative; occasionally, however, definite localizing signs are present. Often the only finding is a dilatation of the pupil on the side of the hemorrhage.

The spinal fluid may be clear or xanthochromic, its pressure normal or elevated. As a rule the total protein is increased.

If the pineal gland is calcified, the diagnosis may often be made by noting a shift of the gland in direct P.A. x-ray views of the skull.

The treatment is operation. Usually trephine openings, with drainage of the hematoma, is sufficient. Occasionally, it will be necessary to turn down an osteoplastic flap. One must also remember that they are not infrequently bilateral.

Blast Injuries:

Although there are many unanswered questions relative to blast injuries, certain facts have been fairly-well established, both clinically and experimentally.

Individuals in close proximity to an explosion, either in air or water, may be killed or seriously injured from the effects of the externally applied pressure wave.

The most common lesions are found in the lungs and gastro-intestinal tract. Lesions are also found in the brain, spinal cord, liver, spleen and kidneys. Air blasts are more likely to produce serious lung lesions, whereas water blasts tend to produce lesions of the intra-abdominal organs. However, serious lung and intestinal lesions may occur with both types of blast injuries.

The pulmonary lesions are bilateral, and vary from alveolar damage and rupture, with capillary bleeding into the smaller bronchioles, to extensive injury and destruction of the large portions of lung tissue, with occlusion of large bronchi with blood clots. Pulmonary edema may occur later in varying degrees.

Two types of lesions are met with in the gastrointestinal tract, namely, contusions and hemorrhage of the bowel wall and perforations. Experimentally, these changes are in direct proportion to the amount of gas in the lumen; and this explains why lesions are more common in the large bowel. Lacerations and contusions of the liver, spleen, and kidneys have been described, but are rare and not seen when normal experimental animals are exposed to blast injuries.

Petechial hemorrhages in the brain and spinal cord have been described by numerous writers. These patients suffer from headache, loss of memory, personality changes, irritability, motor weakness and convulsions.

Treatment:

Persons who have been close to exploding bombs, even if they show no evidence of injury, require observation for twenty-four hours.

Shock is common in these cases, must be looked for, and properly treated if it occurs. Providing the patient's condition permits, x-rays should be taken of chest and abdomen.

The treatment of the chest injuries will be essentially symptomratic: absolute bed rest, sedatives, and oxygen administration for respiratory embarrassment. Pulmonary edema may require hypertonic solutions and vena section. If pneumonia develops, appropriate sulfa-therapy is indicated.

The treatment of intraabdominal injuries will require careful judgment, especially since these casualties also have, as a rule, definite lung pathology. The perforation of a viscus is the one indication for immediate surgical intervention. This diagnosis is rather difficult to make unless the x-ray films of abdomen show the presence of free-air in the peritoneal cavity, or unless there is evidence of spreading perintonitis. When perforation or peritonitis is suspected, continuous gastric suction by the Wangensteen or similar apparatus should be instituted immediately, and continued after operation. The anesthetic, in view of the lung pathology, is local, supplemented by pentothal sodium if necessary.

The therapy of the central nervous system lesions is the same as indicated in cerebral concussion and contusions, because, as stated, petechial hemorrhages scattered throughout the brain are the common lesions.

If cerebral symptoms continue, or especially if they become more marked, the possibility of subdural collection of fluid must be considered; and if diagnostic procedures indicate their presence, trephine and drainage should be carried out.

909 Hyde Street.

THE HOSPITAL: IN EMERGENCY MEDICAL SERVICE*

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San Francisco

SINCE December 7, 1941, the hospitals in the State of California have been undergoing an extensive preparation to defend their plants against damage by fire or enemy bombs. During the same time, they have been carrying on extensive plans for the organization of the personnel, so that they might be prepared to receive large numbers of casualties for treatment within their walls. The interest in the above two programs has increased and waned in keeping with our successes and failures in the Pacific. At the present time, interest in not only hospital protection, but in all types of civilian defense has reached a very low ebb, and it is with much effort on the part of committees that the program is kept alive. It would not be correct to say that the effort of the past many months has been without value, for in a State where natural disaster has previously occurred with much destruction of life and property, any review of our disaster plans is extremely valuable. Many points have been learned from the program to date.

FIRE PROTECTION

Since the outbreak of the war, all buildings have been reviewed for fire equipment. Attics have been cleaned out and roofs have been made more accessible. Perhaps for the first time in many years, fire extinguishers have been completely rechecked and refilled; auxiliary fire fighting apparatus and trucks have been established in every hospital. Hospital personnel have become better acquainted with their neighborhood fire stations and fire-station personnel.

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* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

From the office of the Superintendent, Stanford University Hospitals.

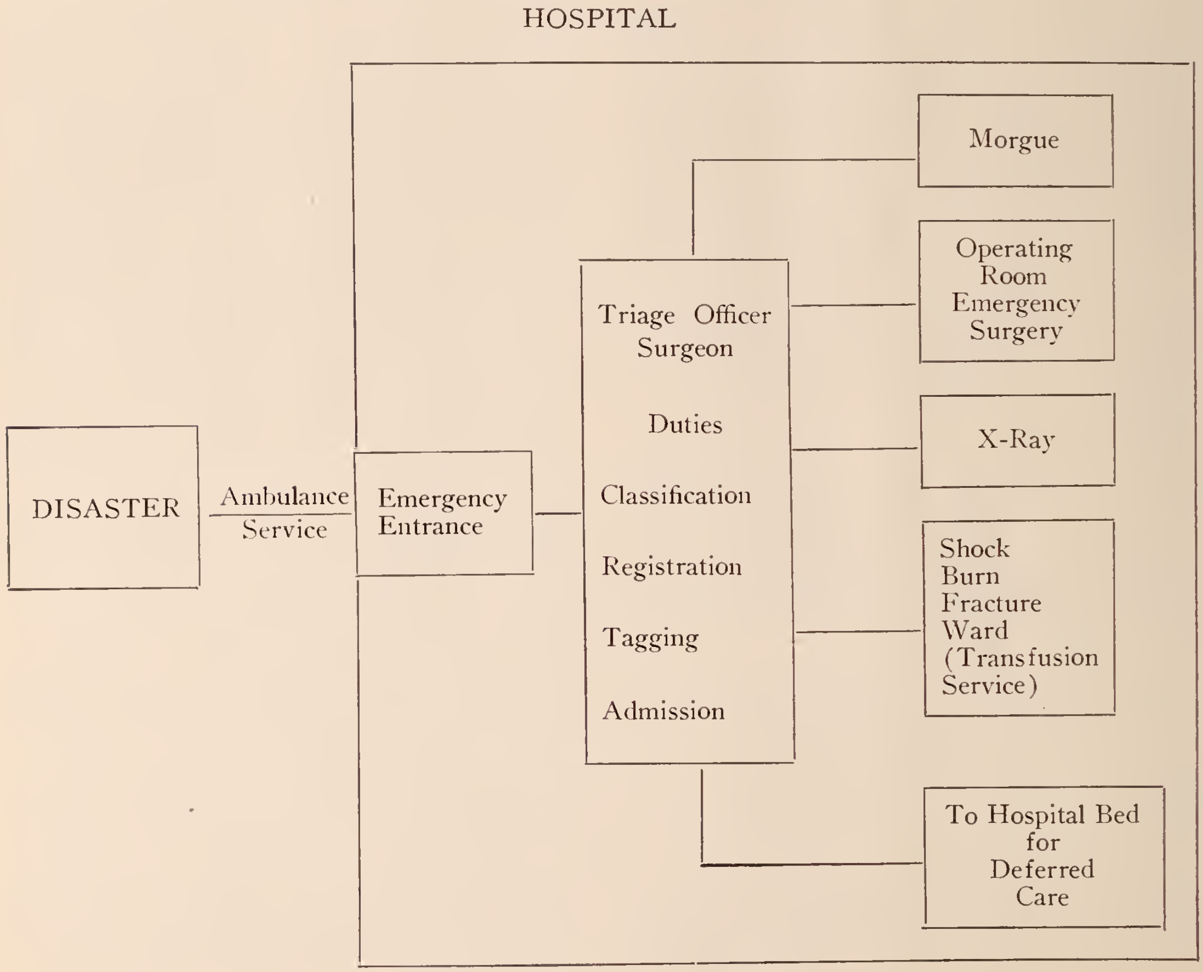
EMERGENCY EQUIPMENT

For the first time during the life of hospital administrators, they have given thought to the possibility of great numbers of admissions in a short period. To handle such a problem, they have organized emergency equipment and have looked for space to expand. At first thought, hospital administrators did not think it possible to devise, even on paper, ways and means whereby hospital capacities could be greatly enlarged. However, upon closer scrutiny, it was seen that class rooms, auditoriums, sun porches and waiting rooms could be quickly converted to temporary wards. It was also realized that existing wards could have their capacities increased and private rooms could be easily doubled. To take care of that expansion, much emergency equipment was obtained from the office of Civilian Defense, the American Red Cross and from the hospital's own supply. Thinking along this line has been of exceptional value, and, as we have seen in certain catastrophes which have arisen in this country from causes other than enemy action, the possibility of great demands for hospital beds may be a reality at any time.

PERSONNEL

The organization of the civilian hospital in peacetime does not call for anything similar to military organization. It was soon realized that a peacetime organization could not function during the time of disaster, and hospital staffs were quickly organized on a military type basis with a single commanding officer and his assisting staff. Transportation of personnel to the hospital during blackouts gave us considerable concern. At the same time, it prompted us to develop house-staff organization of nurses and physicians living at the hospital. Such organizations have been in existence since the early days of the war and, it is felt, will function if called upon to do so. As in peacetime, it was necessary for us to develop specialization programs, and, with this thought in mind, Mobile Medical Teams, Gas Decontamination Squads, Shock and Burn Teams, Transfusion Teams and many other specialization groups were organized, trained and equipped. A skilled surgeon is stationed at the hospital entrance to act as Triage officer. It has been very comforting to observe the ingenuity of our physi-

Table 1.—*Diagrammatic Outline to Indicate Arrangements in a Hospital, for Care of Persons Injured in a Local Catastrophe or Bombing*



cians in devising emergency type equipment and methods.

REHEARSALS

Perhaps the most important functions in morale building and training for disaster have been the rehearsals which have been held. Many lessons were learned in connection with rehearsals. The following seem to me to be the most important:

(1) Rehearsals can be used as a morale-building factor. No other part of our defense program within the hospital seemed to stimulate the enthusiasm and support of the personnel. The publishing of bulletins, and the isolated instances of demonstration, failed to create the needed enthusiasm.

(2) It was evident that all employees of the hospital should participate in some way in order that each might feel a part of the functional unit. This was easily made possible by thought on the part of the Rehearsal Committee.

(3) A sufficient number of casualties should be available and, in my opinion, a sufficient number is 15 more casualties than could possibly be handled with the entire staff on duty, and all equipment available. In earlier rehearsals where only a few victims were admitted, most of the staff did not have an opportunity to work actively. Consequently, they went away feeling that there was too much "make-believe." On the contrary, in those rehearsals where everybody worked, and there was much more than could be done, they went away with the feeling that they had actively participated in a real program.

(4) Activation of all departments should be insured by the proper direction on the tags of the victims. An important point which was learned early in the war was the fact that physicians do not need practice in diagnosis since that is their life's work, and they are participating in that type of activity daily in their routine work. It was evident that we needed practice in traffic management and interdepartmental relationships. In order to carry out this idea, all casualties should be tagged with instructions which will direct them to a specific department, so that the work will be evenly distributed and everyone will be busy.

(5) Casualties should be admitted in such order that all departments will start working as early as possible during rehearsal. This was accomplished by first admitting a patient to the x-ray department; secondly, a patient needing a transfusion; thirdly, a woman in labor for the maternity division; fourth, a patient who needed surgical treatment in the operating room; fifth, an hysterical patient admitted to the psychiatric ward; sixth, a child in diabetic coma to the pediatric ward, etc. In this way, there was no idle time during the first half hour of the rehearsal.

(6) It is very desirable to have a specific point at which time all activities will cease regardless of at what stage the department is functioning.

(7) It is very desirable to have a meeting of all those who have participated in the disaster rehearsal. This meeting should not be a post-mortem of the rehearsal, since frequently unrest and dissatisfaction on the part of a few may be contagious and make others discontented. I strongly advise holding such post-mortems in small groups in specific departments. In this way, the surgical division can review its program regarding shock and burns by itself, etc. I believe that the general meeting should be a morale-building meeting, and the time should be given over to two or three speakers who have some interesting message regarding war effort. It is always amazing to see, collected in one auditorium, the number of people who have participated in a rehearsal, as during the rehearsal this group is spread around the hospital so many places that no one realizes the great number who are functioning during the program. The accompanying diagrammatic sketch shows the arrangement of a hospital for the care of the injured that would come from a local catastrophe or bombing.

SUMMARY

We, of California, can be very grateful for the many points we have learned, and the experience we have had since Pearl Harbor. I am sure that the hospitals and their personnel will be better prepared to meet a disaster of enemy action, sabotage or natural forces because of the concentrated thought we have given the subject during the past months.

Clay and Webster Streets.

SHOCK*

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San Francisco

THE best treatment for shock is prevention. The guiding principle should be early recognition of impending or primary shock, and its early treatment, and thus the prevention of secondary shock. Accepting these premises, it is not difficult to realize the importance of early symptoms. British experience indicates that 20 to 30 per cent of air raid casualties suffer from severe injuries and associated shock. If deaths are to be prevented, it is necessary to treat prophylactically all patients suffering from injuries which may produce shock, rather than wait until classical signs develop before therapy is instituted.

PRIMARY SHOCK

Primary shock due to neurogenic and psychogenic influences follows quickly after receipt of trauma and, unless complicated by loss of blood or other shock-producing factors, is of short duration. The characteristic circulatory change is vasodilation. Sweating, relatively warm skin, low-blood pressure, feeble and usually slow pulse and syncope are the characteristic findings. First aid measures are recumbent position, conservation of body heat and relief of pain. If there is not early favorable response to therapy, or if there is considerable blood loss or damage to tissues, secondary shock may ensue, unless appropriate antishock measures are promptly instituted. Because there is no early pathognomonic sign, and because recognition of early or preshock states is difficult as compared with advanced shock, it is imperative to have experienced medical personnel in attendance, and adequate facilities for observation and treatment near the ambulance entrance to all casualty-receiving hospitals. Preventative treatment at this stage is so important, and so much more easily accomplished than in the full-blown stage described below, that the physician should err on the side of over- rather than undertreatment. A history of trauma, with or without external signs of injury, in a casualty with a clammy pale skin and a pulse rate of 100 persistent for several minutes, is presumptive evidence of impending shock and is sufficient indication for the prompt institution of antishock therapy. Casualties suffering burns which involve more than 10 per cent of the body surface should likewise be considered as potential shock candidates and be treated prophylactically.

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* One of several papers in a Symposium on "Emergency Medical Service in Wartime." Papers collected by Henry Gibbons, III.

Generous use of material and text from O.C.D. publication 2212 was made, as per Reference I.

SECONDARY SHOCK

Secondary shock, caused by tissue damage, is usually later in onset than primary shock, and is likely to develop insidiously an hour or more after injury. Advanced shock is not difficult to recognize. It is characterized by pallor, weakness, fatigue, thirst, cold perspiration, rapid thready pulse, rapid shallow respiration, low-blood pressure and collapsed veins. The mental state of the patient is not a reliable sign of either the presence or severity of shock.

The predominant characteristic of secondary shock is diminution in the effective circulating blood volume, accompanied by compensatory vasoconstriction. This fundamental circulatory disturbance results in decreased cardiac output, diminshed venous return to the heart, inadequate peripheral circulation, and, finally, impaired blood supply to the tissues. Hemoconcentration and progressive diminution in the blood volume occur. If uncorrected, the peripheral arteriolar constriction which served to maintain blood pressure in the presence of a diminshing blood volume, is unable to afford adequate compensation. The peripheral circulation fails, vasodilation ensues, and the blood pressure drops. A fall in blood pressure is therefore a *late* manifestation of shock. Since, due to vasoconstriction, the arterial blood pressure may be normal in the presence of a dangerous reduction in blood volume, *measurement of blood pressure is an inadequate guide to the presence of early shock.* In contrast, blood pressure determinations may be of considerable value in deciding upon the efficacy of therapy, particularly in regard to plasma dosage. Profound physiologic disturbances which are secondary rather than causative factors are acidosis (diminished alkali reserve), oliguria or anuria, and disturbances of various chemical equilibria.

The initial reduction of blood volume in secondary shock may be due either to loss of whole blood (hemorrhage) or to loss of plasma (burned surfaces, injured tissues), or both. Dehydration, fatigue, pain, fear, and exposure to cold contribute further to its development. During the early phases of shock due to hemorrhage, initial dilution of the blood by fluid drawn into the circulation from the tissues occurs, unless dehydration is present. In inadequately-treated shock, especially when hemorrhage has occurred, hemoconcentration due to plasma loss is a relatively late characteristic, representing loss of plasma to the tissues in excess of the loss of whole blood. If adequate therapy is not instituted promptly, such a loss of plasma will lead to irreversible shock much more readily than will an equal loss of whole blood.

When the loss of whole blood predominates over the loss of plasma in a normally-hydrated individual, hemoconcentration may not occur, even though shock is advanced. In such instances hemoglobin and hematocrit determinations will merely show evidence of anemia.

However, low hemoglobin and hematocrit findings, coupled with a low plasma protein level, mean acute blood loss, and indicate the need for prompt plasma therapy to combat shock, followed by whole blood transfusion, if the blood loss has been severe.

PREVENTION OF SHOCK

Since our primary object is the prevention of shock, there should be some emphasis placed upon the handling of casualties up to the time of their arrival at the hospital. Definitive treatment for the varied types of injuries will be covered in other sections of this series, but much can be done to lessen this work by the physician in charge of first aid. This is especially true in shock prevention

Control of Hemorrhage:

Hemostasis should be accomplished, if possible, by elevation of the extremity, the application of pressure dressings, the use of pressure over the artery proximal to the wound, the insertion of sterile gauze packs or even ligation of the vessel if facilities are available. Only when these measures have failed should a tourniquet be applied. British experience has indicated that tourniquets are rarely necessary in the first aid treatment of air raid casualties.

If a tourniquet is used the following precautions are necessary: 1. Both venous and arterial circulation must be occluded. 2. TK should be marked on the casualty's forehead and the time of application noted on casualty identification tag attached to the wrist at the site of the incident. 3. No bandages should cover or hide the tourniquet. At the receiving hospital, loss of plasma into damaged tissue should be prevented by substituting pressure dressing for tourniquet or amputating before its removal.

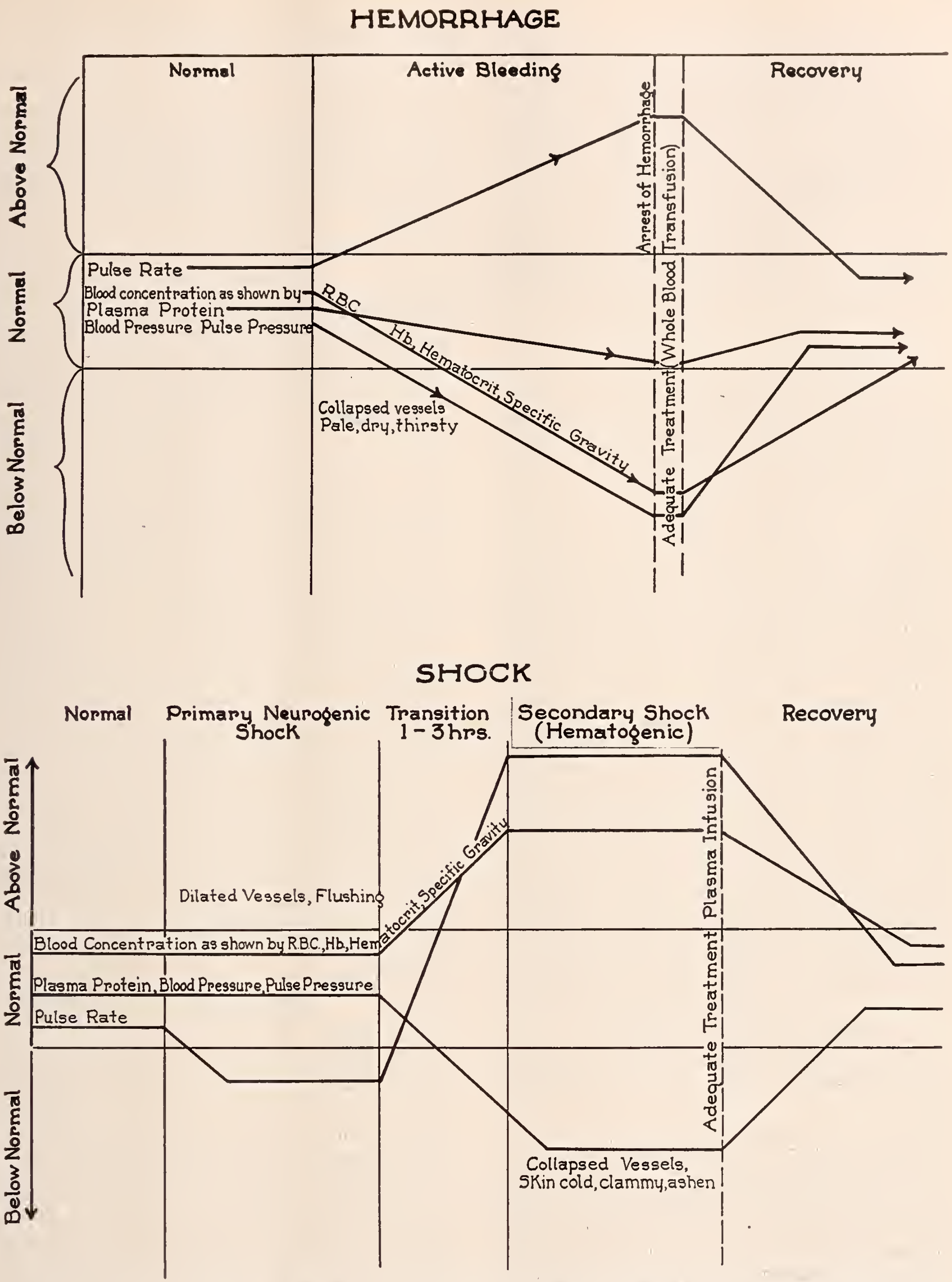

Fig. 1 and Fig. 2.—Graphic Comparison of Shock and Hemorrhage as Shown by Physical and Laboratory Tests.

Relief of Pain:

Since pain is one of the prime factors in producing shock, its early relief by hypodermic administration of ¼ to ½ grain of morphine is indicated. This should be almost routine except that in restlessness and pain due to intracranial injuries sodium phenobarbital or sodium amytal are indicated in adequate dosage. In many cases morphine should be given before rescue from fallen timbers is begun. The time and dose should always be noted on the identification slip.

Immobilization of Fractures:

Splinting of fractures results in minimizing two important factors in the production of shock-soft tissue damage and pain. Every effort should be made to splint fractures before transportation, and the experience in England has shown that traction splints are seldom necessary or advisable for transportation over city streets to the receiving hospital. Well-padded splints fixed firmly above and below, but not over the fracture site, are the best and most easily applied means of immobilization. These should include joints on either side of the fracture. Folded newspapers, blankets or pillows are often satisfactory.

Care of Wounds:

The care and promptness of the first aid treatment of open wounds (including burns) is of great importance in determining the likelihood of subsequent severe infection. It is better to leave a wound undressed than to give first aid carelessly.

As a result of British experience with the first aid treatment of air raid casualties, several points may be emphasized. Most air raid victims are extremely dirty and begrimed, their wounds are contaminated with dust, dirt, and débris, making impossible any attempt at adequate cleansing by first aid workers. Emphasis should be placed on the rapid removal of casualties from the site of disaster to casualty-receiving stations or hospitals, where facilities necessary for proper treatment are available. Unless a wound is bleeding profusely, it should be left alone except for the application of a sterile dressing to prevent further contamination during transportation to a place where aseptic technique can be observed. The chief exception to this rule is in the care of a sucking wound of the chest where immediate sealing by the best available means should be carried out. A moist dressing held in place by pad snugly strapped to the chest by adhesive serves well. Sterile sulfa powder should be sprinkled in the wound before application of sterile dressings. No strong antiseptics should be used.

Further contamination of wounds by droplet infection should be avoided by those giving first aid.

Maintainence of Body Temperature:

Since a definite relationship exists between the loss of body heat and the onset of shock, every effort should be made to prevent or correct chilling. Blankets under and over the patient, preliminary dressing in a warm place, removal of wet clothing and warming devices in the ambulance or other transportation are the safest and most easily-applied measures. The use of external heat must be cautiously applied because of the danger of burns and the danger of overheating. The latter danger has been emphasized by British experience (2) where it has been suggested that further depletion of an already reduced volume of circulating fluid may be brought about by peripheral vasodilation.

Shock Position:

In general a positon with the head slightly below the horizontal is advisable to maintain circulation to the brain, but this procedure must be avoided in head injuries and where uncontrolled bleeding of nasal and other head and neck wounds is present.

TREATMENT OF SHOCK

Restoration of the circulating fluid volume to normal is the prime and most important therapeutic measure, not only for prevention of, but for treatment of established secondary or traumatic shock. Rapid and lasting accomplishment of this restoration of blood volume is best attained by intravenous infusion of adequate amounts of whole blood, blood plasma or serum. There is no accurate way in which to predict the proper dosage. The all-important point is to give blood plasma or serum early, and to give it in sufficient quantity to produce the desired effect. Restoration of normal blood volume is the aim. The quantity must be sufficient to accomplish this. Any quantity less than this means that the patient has been inadequately treated.

The two rules which follow are of value in estimating the amount of plasma necessary for treatment, but final dosage is based upon *clinical* results: (1) give 100 c.c. of plasma for each point the hematocrit reading is above the normal of 45, and (2) where hemoglobin determinations are used, give 40 c.c. of plasma for every point the hemoglobin reading exceeds 100.

The decision as to the use of whole blood or plasma should be made upon whether hemorrhage has accompanied or has been contributory to the shock. Although the establishment of blood banks in many communities has lessened the difficulty of obtaining suitable whole blood, the trend of emergency treatment is toward blood derivatives such as plasma, serum and serum albumen for shock because of the ease of transportation, storage and administration. Their chief virtue lies in the fact that the protein content restores blood plasma volume physiologically, while at the same time they can be given more rapidly than whole blood and without the necessity of typing or cross-matching.

The rare air raid casualty that dies of hemorrhage is usually the one that succumbs to acute blood loss before medical aid is available. So long as normal blood volume is maintained by plasma infusions, the transfusion of whole blood can almost be relegated to a nonemergency procedure to be used for the replenishment of erythrocytes in the cases of prolonged bleeding or posttraumatic anemia.

SERUM AND PLASMA

Since whole blood is rarely indicated in air raid emergencies and since serum albumen, bovine and other preparations are still in the experimental stage, the following discussion will be devoted to serum and plasma.

There is little difference between the relative virtues of plasma and serum, provided both have been properly prepared (i.e., sterile and free from pyrogens).

Plasma is suitable for use without preliminary laboratory typing and compatiblity tests, and is free from the danger of severe reaction attendant on the use of whole blood. It is not necessary to warm plasma before administration, and it can be given as rapidly as the needs of the recipient warrant. It must be filtered, however, while being administered.

Plasma is currently stored in one of three ways: namely, as liquid plasma, frozen plasma or dried plasma and is prepared and administered as shown below. Liquid plasma is the basic form and may be stored for one year at room temperature provided enough 50 per cent dextrose has been added to make a 5 per cent final concentration of dextrose.

ADMINISTRATION OF PLASMA

As a general rule, plasma should be given by the intravenous route, as are glucose and saline solutions. A filter is always used in the intravenous set-up. There are many times, however, when, because of extensive burns or collapse of the veins due to profound shock, the intravenous administration is difficult or impossible. In these instances the most effective and rapid method of reaching the general circulation is by introduction of a needle into the bone marrow of the sternum in adults or the tibia or femur in children. The technique of this procedure is simple. The skin is prepared in the usual manner, then 2 or 3 c.c. of 1 per cent procain are injected in skin and periosteum, a short, styletted 10-to-20 gauge, needle is introduced at an angle of 45 degrees to the skin surface with a rotating or boring motion until a sudden decreased resistance is noted. This indicates that the needle has entered the marrow space. The stylet is removed, a syringe applied and marrow fluid aspirated. The intravenous set is attached to the needle and either rapid or slow infusion is carried out.

PREPARATION OF PLASMA FOR USE

1. Liquid plasma should be kept at a temperature of 55° to 100° F. and is available for immediate use.

2. Frozen plasma must be properly thawed before administration; otherwise, considerable precipitation of fibrin will occur. The precipitation of fibrin does not render plasma toxic, but makes it extremely difficult to administer. In order to prevent this, it is necessary to thaw the plasma rapidly in a constant temperature water bath at 98.6° F. (37° C.). Thawing is usually complete within 20 to 30 minutes. The speed of thawing may be increased by providing for constant circulation of water in the water bath. In an emergency, it is possible to thaw plasma adequately in tubs and basins, using the available supply of hot and cold water providing the temperature is maintained with a thermometer at 37° to 40° C. If controlled temperature hydrotherapy baths are available, they will serve ideally for the thawing of frozen plasma.

3. Instructions of reconstituting dried plasma are furnished with each individual package.

4. Plasma or blood should not be artificially heated except by means of a 98.6° F. (37° C.) water bath.

5. Administration of blood or plasma at room or even at ordinary ice-box temperature 35° to 42° F. (2° to 6° C.) is not harmful.

SURGICAL TREATMENT OF CASUALTIES EXPOSED TO SHOCK-PRODUCING INJURIES

(a) *Time of Operation:*

Early operation on casualties is indicated for many reasons. This is particularly true in those instances in which bleeding cannot be stopped by simple means, and in which there are penetrating wounds of hollow viscera, such as the intestinal tract. The length of time separating the injury and operation is an important factor in determining how wounds should be treated, and whether shock and other complications will develop. In general, it may be stated that the mortality will vary directly with the time intervening between the major injury and operation. *Plasma or blood should be given during and after the operation to prevent relapse into the shock state.*

(b) *Anesthesia:*

Since only in the most exceptional circumstances should any operative procedures be undertaken while a patient is in shock, it will rarely be necessary to use anesthesia in shock cases. There are three main points to be borne in mind before administering an anesthetic agent to a patient who has suffered shock: 1. Deep anesthesia in any form is contraindicated. However, it must be remembered that inadequate anesthesia may itself result in shock. 2. The amount of anesthetic agent that will produce light anesthesia in normal patients may be an overdose for such patients. 3. Respiratory function must not be embarrassed by undue stimulation, interference with the airway, or inadequate oxygenation.

The ideal anesthetic to be used in these patients has not been found. Problems which influence the choice of anesthetics are the general condition of the patient, the type of wound, the part of the body involved, and the length of time between injury and operation. In addition to strictly physiologic factors, other considerations are also important in choosing anesthetics for emergency purposes. These include bulk, weight, transportability, explosibility, and fire hazard.

Air raid casualties who are buried under débris require special consideration. They are likely to be in shock, and often suffer from dehydration. Extrication from wreckage may in some instances be possible only by amputation of a limb. The type of anesthesia administered to such casualties will depend on the part of the anatomy in reach, the choice usually lying between open ether, intravenous morphine, or barbiturates. Patients with facial injuries likewise present special anesthesia problems. Under such emergency conditions intravenous barbiturates may be useful when there is no danger of inhaling blood and when veins are accessible. In some instances endoctracheal anesthesia may be necessary.

Nitrous oxide-oxygen anesthesia gained considerable popularity in the last war, due in large part to the observation that animals anesthetized with gas-oxygen mixtures were more resistant to histamine shock than those anesthetized with ether.

Cyclopropane is a satisfactory anesthetic agent for casualties who have suffered from shock, because it can be administered with high concentrations of oxygen and with minimum toxic effects. The greatest drawback to its use is its high explosibility. As with other gaseous anesthetics, there is difficulty in transportation because of cylinder bulk. *Ethylene* presents no significant advantages over cyclopropane.

Ether is probably the safest of all inhalation anesthetic agents, especially when combined with oxygen. It appears likely that its harmful effects, except for prolonged operative procedures, have been overemphasized.

Spinal anesthesia is ideal for operations on the lower extremities and lower abdomen in patients *in whom the blood volume and blood pressure are not significantly depressed.* It should *never* be used on a patient who is in shock or has recently recovered from shock.

Recent advances in the use of *intravenous anesthetic* agents indicate that they may be suitable for brief anesthesia in patients suffering from traumatic injuries. A number of short-acting barbiturates are available and, if given in small amounts repeatedly, they may be of value under special emergency circumstances. The use of these drugs is, however, not without danger. One should avoid large doses of such agents in casualties in poor condition, since they are capable of causing histotoxic anoxia. It is essential that an attendant be present at all times in order to make sure that an open airway is maintained and that a high concentration of oxygen is supplied in the inspired air. Intravenous agents have the advantages of small bulk and weight, and freedom from fire and explosion hazards.

Local or regional block anesthesia is the best for operations on patients in shock and should be used whenever possible.

From the anesthesia viewpoint, all hospitals treating casualties can function quite satisfactorily with a few relatively simple substances; namely, procaine, and intravenous barbiturates such as pentothal, and oxygen-ether.

(c) *Penetrating Wounds:*

Penetrating wounds require special consideration because improper treatment of them is likely to result in shock. The care of these wounds is covered in another paper of this symposium.

(d) *Postoperative Care:*

The postoperative care of a shocked patient is similar in many respects to his preoperative care and is as important. *After operation, careful observation and treatment of the patient are necessary to prevent recurring shock.*

SUMMARY OF SHOCK TREATMENT

1. Prevent its development.
2. Stop bleeding.
3. Relieve pain.
4. Avoid continued tissue damage by such measures as splinting of fractures, et cetera.
5. Maintain body temperature—prevent chilling—do not overheat.
6. Place in shock position, unless contraindicated.
7. Give sufficient whole blood, plasma, or serum as soon as possible.
8. Administer warm fluids as indicated.
9. Choose an anesthetic agent which will not aggravate the condition.
10. Do necessary surgery as quickly, and with as little tissue damage, as possible, but only after shock has been controlled.
11. Carefully observe the shocked patient postoperatively. Do not let him relapse into shock. Remember that the primary disturbance in shock is diminution in the effective circulating blood volume. Treat it by intravenous administration of blood, plasma, or serum.

384 Post Street.

REFERENCES

1. OCD Publication 2212: The Clincal Recognition and Treatment of Shock. Copies of this publication may be obtained upon request from your local OCD.

2. Foreign Letters, London: J.A.M.A., v. 122, p. 886, July 24, 1943.

3. Moon, V. L.: Shock, Lea & Febiger, 1942.

4. Fox, Chas. L.: Oral Sodium Lactate in the Treatment of Burn Shock. J.A.M.A.. v. 124. p. 207. Jan. 22, 1944.

(C.P.S. Continued from Page 208)

for C.P.S. to operate its professional program free-handedly. It would seem, therefore, that when, as and if government participates widely in the provision of medical service for the population or parts thereof, C.P.S. and similar organizations could well be used as the instruments to furnish the professional services required under the programs.

At the conclusion of the Secretary's testimony, Senator Pepper stated that C.P.S. will be the object of further study by his committee.

Dr. Larsen and the Secretary left Washington feeling that the attitude of Senator Pepper and his committee is one of deep interest in the extension of medical care and the methods by which it may be accomplished, with due consideration for the rights and customs of the various groups concerned.*

153 Kearny Street (8)

If you have genius, industry will improve it; if you have none, industry will supply its place.—*Sir Joshua Reynolds.*

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* Mr. Albee Slade discussed a general health program and California Physicians' Service, but Secretary Kelly and Medical Director Larsen of C.P.S. had to leave before Mr. Slade made his remarks.

CALIFORNIA PHYSICIANS' SERVICE*

REPORT ON HEARING BEFORE U.S. SENATE SUBCOMMITTEE ON WARTIME HEALTH AND EDUCATION

T. Henshaw Kelly, M.D.
San Francisco

ON August 24, 1944, the Secretary of the Board of Trustees of California Physicians' Service received a telegram from the Honorable Claude Pepper, United States Senator from Florida, Chairman of the Subcommittee on Wartime Health and Education of the Committee on Education and Labor, requesting his presence on the morning of September 20th to testify before the Subcommittee concerning the organization and purposes of California Physicians' Service. After consultation with President Ray Lyman Wilbur, a wire was sent, stating that the Secretary would be present, and it was decided further that in order to have the greatest amount of information available to the committee if it so desired, Dr. Larsen, the Executive Medical Director would accompany the Secretary.

The Secretary and Dr. Larsen arrived in Washington on September 17th, and attended hearings before the committee on September 18th, 19th and 20th, and had numerous consultations concerning C.P.S. and its activities with representatives of the Social Security Board, the United States Public Health Service, the Federal Public Housing Authority and the Farm Security Administration.

The members of the Senate Subcommittee on Wartime Health and Education are: Claude Pepper (Florida), chairman, James M. Tunnell (Delaware), Elbert D. Thomas (Utah), Robert M. LaFollette (Wisconsin), Kenneth S. Wherry (Nebraska).

Heard before the committee were:

Monday, September 18th:

1. Dr. R. L. Sensenich, Board of Trustees, American Medical Association
   Dr. Harvey Stone, Committee on Hospitals and Medical Education, American Medical Association
2. Dr. Roger I. Lee, President-Elect, American Medical Association, and Chairman, Joint Committee on Postwar Medical Service
   Prof. Walter W. Palmer, Chairman, Committee on Postwar Medical Service, American College of Physicians
3. Mr. William Green, President, American Federation of Labor (or a personal representative of Mr. Green)
   Mr. Robert Watt, International Representative, American Federation of Labor
4. Dr. Jean Curran, Dean, Long Island College of Medicine, and member of the board, Bingham Associates Fund
   Dr. Samuel Proger, Medical Director, Pratt Diagnostic Hospital, Boston, Massachusetts
5. Dr. C. Rufus Rorem, Director, Hospital Service Plan Commission (Blue Cross Plans)

Tuesday, September 19th:

1. Mr. Philip Murray, President, Congress of Industrial Organizations (or a personal representative of Mr. Murray)
   Mr. George Addes, Secretary-Treasurer, United Automobile Workers, Congress of Industrial Organizations
2. Dr. Victor Heiser, Chief Medical Consultant, National Association of Manufacturers
3. Dr. Leverett D. Bristol, Chairman, Health Advisory Council, U.S. Chamber of Commerce
4. Dr. John P. Peters, Secretary, Committee of Physicians for Improvement of Medical Care
5. Dr. George Stevenson, Medical Director, National Committee for Mental Hygiene
6. Dr. E. I. Robinson, President, National Medical Association

Wednesday, September 20th:

1. Dr. Ernst P. Boas, Chairman, Physicians Forum
2. Dr. John Radford Boling, President, Florida State Medical Society
3. The Honorable Fiorello LaGuardia, Mayor, New York City
4. Dr. Perry Prather, General Practitioner, Hagerstown, Maryland
5. Dr. T. Henshaw Kelly, Secretary, California Physicians' Service
6. Mr. Albee Slade, Congress of Industrial Organizations.

The representatives of C.P.S. were deeply interested in the nature of the material which the committee, with Senator Pepper doing the questioning, was endeavoring to develop, as they had heard various reports as to the purposes of this committee in holding these hearings. It became evident that Senator Pepper feels that the Wagner-Murray-Dingell Bill may have rough sledding, and being himself interested in the development of increased medical service in the United States, is considering the development of a bill which might accomplish this purpose without going as far as national compulsory prepaid medical care.

Perhaps the purpose of this hearing can best be explained by the questions which Senator Pepper asked everyone who testified before his committee:

1. Do you believe that there is sufficient good medical service available to all the people of the United States?

2. Do you agree that the Federal Government should appropriate money which could be matched on an equitable basis by money from states or political subdivisions thereof, to provide and equip hospitals, diagnostic centers, infirmaries or other

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* Ed. Note.—For easier reference, the report by Dr. T. Henshaw Kelly is placed in this department of CALIFORNIA AND WESTERN MEDICINE.

necessary medical facilities in areas where they do not now exist, the need therefor to be shown by the states or political subdivisions thereof and approved by such federal authority as might be named in the act?

3. How should these facilities be staffed and operated to the best interests of all concerned?

4. Do you believe that the Federal Government should appropriate funds to be matched as above, which funds could be used to further the development of, or initiate, plans for the furnishing of prepaid medical care in cities, counties or states where they already exist, or where they might be initiated after the plans have been approved by the state authority and the Federal authority named in the act?

5. How do you believe that these funds could best be used to accomplish the above purpose?

The great majority of those appearing before the committee agreed that there must be some effort made to provide prepaid medical service for large groups of people by some means or another. The representatives of the A. F. of L. and the C.I.O. and Mayor LaGuardia plumped flat-footed for the Wagner-Murray-Dingell Bill, while in general the opinions of the others leaned toward the stimulation and extension of voluntary plans in which the matter of subsidy for some of the low income groups might be considered.

Senator Pepper himself, during the course of the hearings, stated that it is his firm determination to see these purposes, described above, carried out, but that as he is a "good States' rights-er," he leans towards methods suggested by his questions rather than to nation-wide compulsion, and that he believes that from the development and operation of numbers of plans, much may be learned about how to formulate a national plan, if that should become necessary.

The answers to the other questions by most of the participants were fairly generally theoretical, and in some cases nebulous, but most of them yearned towards professional control of the medical service to be provided.

It is not presumptuous to say that California Physicians' Service, with five years of operation behind it and its experiences with the Rural Program for the Farm Security Administration and the War Housing Program with the Federal Public Housing Authority, has practical answers for all of Senator Pepper's questions.

Little time was spent by the Secretary in going over the organization and operation of C.P.S., as that had been covered in a long prepared statement filed with the committee, and he devoted most of his time before the committee to the answers to the questions mentioned above.

1. C.P.S., by its very organization, recognized the need for prepayment of medical service by large groups of the population, and in its operations has found the lack of effective medical facilities in considerable areas in California, and has cared for large groups of people from other areas in the country whose physical condition is mute testimony to lack of medical care.

2. Federal funds are undoubtedly necessary in some parts of the United States to provide lacking medical facilities, and in other areas not so poor, will do much to stimulate the provision of such facilities not already provided. Senator Pepper himself laughed, and said that if the Federal Government made half a million dollars available to a State on a 50-50 basis, if the present governor of the State did not get that money, "the next governor would."

3. C.P.S. is already operating with its own staff facilities which were provided by the Federal Government on the War Housing Projects in which C.P.S. operates its medical service program, and this operation of Federally-owned facilities goes on without difficulty or interference by the governmental agencies in the medical service program. This could well serve as a pattern for the operation of much larger facilities in the communities wherever they might be provided.

4. It has already become evident to C.P.S. that the indigent population and the lowest income workers will undoubtedly require funds other than their own for their satisfactory medical care. For the indigents, these funds now are and will be derived from tax money. The funds necessary for the low income workers must also come either from industry, as part of their wage, or from tax money, or both. C.P.S. has noted an increasing participation by employers in the prepayment of their employees' medical care, and it can be argued that the health of a man and his family is part of a reasonable reward for his work. However, it is unquestionable that participation by the Federal Government and states or political subdivisions thereof in the prepayment of care for these groups will hasten the provision and extension of their medical service.

5. Funds made available could be used to assist in the development of plans already existing and operating, if such plans are approved by the designated authorities, both state and Federal, or could be used to initiate the organization and operation of other plans in needy areas, after similar approval. The character of plans would of necessity differ in different areas, and much could be learned from their experience. C.P.S. itself has already learned that medical service plans can be operated for the Federal Government without interference by the Federal agencies in the professional control of the medical service, and there is no doubt that a satisfactory State-wide medical service plan could be operated by C.P.S. for any given group of the population, as an agent of the government, working under agreements along the lines of those existing with the Farm Security Administration, the Federal Public Housing Authorities and the Local Housing Authorities. There has always been considerable, and at times violent, discussion concerning the terms and content of the proposed agreements or contracts with the governmental agencies concerned, such as occurs frequently when private contracts are under consideration, but once the terms have been agreed upon, it has been possible

(Concluded on Page 206)

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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Albert J. Scholl, Los Angeles

Pharmacology:
W. C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

U. S. Casualties 389,125

Losses for Army, Navy Announced

Officially announced casualties among the United States fighting forces have reached a total of 389,125.

Secretary of War Stimson said on September 14, that Army casualties for all theaters through August 29, based on reports to next of kin, total 327,616, an increase of 21,821 from the total given a week ago. The latest Navy casualty list reports 61,509, an increase of 1,545.

The Army casualties, with comparable figures for a week ago, follow: Killed 62,357 and 57,677; wounded 172,042 and 156,933; prisoners 48,181 and 45,218; missing 45,036 and 45,967 (A reduction arising out of transfer to other categories).

Of the Navy total, 24,450 were killed, an increase of 524 over the previous week; 23,064 wounded, an increase of 1,170; 9,529 missing, a decrease of 149; 4,466 prisoners, unchanged from the previous week.

Board Told of Navy Plan for New Hospital in San Francisco

Plans for construction of a $6,000,000 Naval Hospital in the vicinity of McLaren Park were disclosed to the San Francisco Board of Supervisors on September 11.

Supervisor Dewey Mead made the disclosure when the problem of setting new boundaries for the park came before the board. He said he had been advised by a Navy officer that the project will require about 100 acres of land.—San Francisco *Examiner,* September 12.

Richmond Doctor Shortage

Numerous complaints on the serious shortage of medical care in Richmond are well founded, city officials, labor leaders, local doctors and Federal and State officials were informed at a meeting held on August 25, called to discuss the vexing problem.

Dr. Harold Fletcher, state chairman of the procurement and assignment service, was authority for the statement on the lack of adequate medical care, as the representatives in attendance discussed future plans by which they hope to bring more doctors to Richmond.

The group was told that in pre-war Richmond there were 22 doctors. The population of the area has increased more than 100,000 and the number of doctors has increased by two to 24.

At the same time it was pointed out by labor representatives that while the nation enjoys one doctor to every 1,500 persons, the war crowded community here has one doctor to every 5,600 people.

The round table discussion, held in the Labor Temple on Fifth street, lasted three hours and during the meeting labor representatives declared that it is possible the U. S. Public Health Service will be asked to send doctors into the area wearing the uniform of the public health service.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

"Under such circumstances," labor said, "the doctor would have an assured income, he would not be subject to state licensing laws and could be withdrawn when the war was over and the population assumed more stable proportions. He would not be competing with local doctors."

The procurement and assignment service representatives admitted that they need at least eight or 10 doctors in the area, but "we can not solve the problem because we do not have the authority to bring these doctors in here."

Labor indicated that it would seek legislation "to permit loosening of restrictions during this critical period to permit some solution of a dangerous situation."

Another proposal from labor was that a local medical advisory committee be formed under the representation from psysicians, auspices of the city council with labor and business. Richmond physicians present indicated their approval of this plan.

Los Angeles County Doctor's Missing Book Found With Dead Japanese

When Dr. Edwin Lee of Downey, Calif., was a student at Loma Linda Medical Division of the College of Medical Evangelists of Los Angeles, an instructor told the students to buy Kellogg's Surgical Approaches to Anatomy. Dr. Lee bought his volume and put his name on the fly leaf. One day it vanished from his book shelf. He sought it in vain and finally bought another. The other day he received the book from a former classmate, Major L. Lawrence Whitaker, medical officer with the American forces that took Attu. The major and another Loma Linda classmate had discovered it in a Japanese hospital on the island, following the occupation by the Americans. A letter from Major Whitaker told Dr. Lee of the weird incident of finding the book. After the Americans had completed the bitter job of wiping the tenacious Japs out of Attu, Major Whitaker and a group of officers examined the garrisons where the Jap command had its headquarters. When they entered the underground hospital they found that 18 of the Jap wounded had been killed by morphine. They lay on their backs, their hands folded across their chests, stiff in cold death. The doctor who had killed his patients lay sprawled on the floor—he had put a bullet through his head. Major Whitaker and his classmate recognized the doctor as their former classmate Paul Tatsuguchi, who had been in college with them for four years. He had received his medical degree with them and had taken the California state medical examination with them when they did.

The two officers found his personal effects and, in going through them, discovered a diary which he kept in English during the last sixteen days, when the Japs realized that resistance would prove useless. He related what was happening as the battle of Attu began depleting the Jap garrison and wounded soldiers were being brought to the hospital. He methodically set down the number of patients he was treating and what he was doing for each one. He told how he had contracted diarrhea and how ill he was. On the last day, when the Japs knew that the end had come, he described how he had killed each of his patients. He wrote a farewell note to his wife and two children who lived in Japan. In final rite he wrote a rededication of himself to his emperor, setting down a renewal of his oath and then, according to the grim evidence, took his life.

In addition to the diary, one of the Loma Linda classmates picked up a volume that had a familiar appearance; it was "Surgical Approaches to Anatomy," a book that recalled many memories. The two officers examined it, and there on the fly leaf they found the name of Ed Lee. It had been crossed out and beneath it was written that of Paul Tatsuguchi.

Citation for Commander Glenn G. English (MC) U.S.N.R.

Saipan, Marianas Islands—(Delayed)—For his intrepidity and courage in establishing an aid station to care for and evacuate wounded Marines during the first bloody hours of the fight for Saipan, Navy Commander Glenn G. English, 46, of Los Angeles, a member of the Los Angeles County Medical Association, has been highly praised by Colonel James P. Riseley, commanding the Sixth Marine Regiment.

Colonel Riseley described the "conspicuous gallantry" of Commander English, who, as regimental surgeon, "landed and established a sorely needed aid station despite terrific mortar, artillery and small arms fire that was falling on the beach strewn with dead and wounded men.

"While others were taking cover," he said, "Commander English went about his work with cool efficiency, disregarding the heavy enemy fire that was causing many casualties about him. The gallant action of Commander English in caring for the wounded without regard for his personal safety, despite this heavy fire, saved the lives of many wounded Marines.

"His courage and bravery were an inspiration to the officers and men under his command and to wounded Marines arriving at the beach."

Commander English makes his home with his wife at 1017 South Orlando Avenue, Los Angeles. He served with the Marines on Iceland, at Guadalcanal, Tarawa, Saipan and Tinian. He is an Indiana University graduate.

National Postwar V.D. Control Conference

A national conference on postwar Venereal Disease control will be held in St. Louis, Missouri, November 9-10-11, under the auspices of the U. S. Public Health Service.

Purpose of the meeting is to bring together leading experts in all phases of VD control who will determine the best methods for giving wide application of recent advances in treatment of both syphilis and gonorrhea. Special emphasis will be devoted to the problems of VD control during the postwar demobilization period.

Because millions of Americans will be returning from foreign lands, and because an enormous increase of travel to and from the United States after the war is expected, effective VD control will undoubtedly require international coöperation.

The USPHS, the National Research Council, and medical departments of the Army and the Navy will report their findings on the effectiveness of penicillin in syphilis and gonorrhea, and recommend treatment procedures. State and local health authorities will advise as to how new treatment measures may be applied locally. Private hospitals and physicians will recommend how they can best participate. It is expected that the rapid treatment center program will be discussed at length and particular attention given to how centers can be used most effectively in the postwar period, both for control and for research purposes. Wider and better use of public education and appropriate social protection measures will also be considered.

Surgeon General Thomas Parran will preside over the conference; Doctor J. R. Heller, Jr., Chief of the Venereal Disease Division, will outline to the conferees specific questions which the U. S. Public Health Service feels require answering.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

ON PROPOSAL TO LOWER LICENSURE STANDARDS IN CALIFORNIA

Excerpts from Letters Received from Officers of California Medical Association and from Associated Groups or Organizations

In this column, and also in the editorial department, comment is made concerning an item which appeared in the *Journal of the American Medical Association* of September 23, on page 243.

The *J.A.M.A.* item is reprinted below; also a copy of a letter dated September 27, which was sent to various C.M.A. officers and others. Then follow excerpts from some of the replies to the letter. Members of the California Medical Association may be interested to scan the reaction of their officer fellows to the proposed licensure recommendations. Statistics concerning number of Doctor of Medicine licentiate in California are also given. *J.A.M.A.* item follows:

A meeting of the Committee on Postwar Medical Service was held on September 9 at the Waldorf Astoria Hotel in New York City. The following members and guests were present: Dr. Roger I. Lee, chairman, Dr. Irvin Abell, Dr. Francis G. Blake, Dr. F. F. Borzell, Dr. Frederick A. Coller, Mr. Graham E. Davis, Dr. Morris Fishbein, Dr. Alan Gregg, Dr. Charles M. Griffith, Mr. B. A. Horning, Dr. E. E. Irons, Dr. Victor Johnson, Mr. E. R. Loveland, Lieut. Col. Harold C. Lueth, Dr. W. W. Palmer, Col. George M. Powell, Dr. W. C. Rappleye, Father Alfonse Schwitalla, Miss Mary Switzer, Dr. Olin West and Dr. Ralph C. Williams.

The chairman reported the loss of a valued member of the committee, Dr. William C. Breed of Boston, who died in August, and stated that the vacancy thus caused would be filled by the appointment of Dr. Morris Piersol of Philadelphia. . . .

Provisions for Licensure of Returning Officers

There appeared before the committee Dr. Barton of the Procurement and Assignment Service, Mr. Wheaton of the War Man Power Commission, Mr. Robinson of the Council of State Agencies and Mrs. Gallaher of the Department of Justice to solicit opinion on a proposal relating to the amendment of the medical practices acts of the states by adding the following:

"If an applicant presents evidence satisfactory to the board that he (1) has been graduated by a medical school reputable and in good standing as determined by the board, has been licensed by a state of the United States, (2) has served in the active military or naval service on or after Sept. 16, 1940, and prior to the termination of the present war as a commissioned medical officer of the Army or Navy and has been discharged or released therefrom under conditions other than dishonorable or has rendered medical service during the period 1940 to 1945 in industry or in a civilian community and (3) is of good moral character, the board in its discretion may issue him a temporary license for a period of time to be fixed in the license issued to practice medicine in this state without requiring that he pass any examination (including a basic science examination if that is a condtion precedent to licensure) that otherwise he would be required to pass. An application for such a license shall be on a form approved by the board and shall be accompanied by such fee as is required for other licenses issued without examination."

This amendment is to become effective at once and is to remain in effect until the governor, on the recommendation of the state board of medical licensure, proclaims that this amendment is no longer necessary.

After discussion, the following resolutions were passed unanimously by the committee:

1. That the Committee on Postwar Planning announces its approval of the proposed legislation;
2. That the committee recommends that the Council of State Governments be requested to give active support to the proposed legislation in the various states;
3. That the committee recommends to state medical associations that they support such legislation and that such associations obtain the assistance of the Procurement and Assignment Service of the War Manpower Commission through its state representatives, and
4. That the committee recommends to state medical associations that they appoint liaison officers to correlate the efforts of those supporting this legislation.

(Copy of Letter to Councilors and Other Officials)

CALIFORNIA MEDICAL ASSOCIATION

Subject: Proposed Change of Medical Licensure for California. (See *Journal A.M.A.*, September 23, 1944, on p. 243.)

San Francisco, September 27, 1944

Dear Doctors:

The *J.A.M.A.* of Sept. 23rd, on page 243, in its report on "Postwar Medical Service" by the "Committee on Postwar Medical Service" prints resolutions that should have special interest to California physicians.

* * *

At the present time, California Medical Association reports that 2,151 of its members are in military service. C.M.A. members who remain in civilian practice are obligated to safeguard the rights of these military colleagues; so that when these army and navy surgeons are mustered out of service, they will have a fair chance to reëstablish themselves in their former or other California communities, and again build up practices to support themselves and their families.

Licensure Statistics (M.D.s) for California

Tabulated below are California medical licensing statistics for recent years, with the exception of the number of licentiates who have entered the Armed Forces year by year, from 1939 to the present date (October, 1944).

(Figures are on Physicians and Surgeons (M.D.'s) only and do not include other licentiates.)

Year	*California Licentiates: Residing in California (as of March 3 of Each Year)*	*California Licentiates: Living in Other States (as of March 3 of Each Year)*	*California Certificates Issued During the Year*	*California Licentiates Endorsed by California to Other States:*	*California Licentiates Who Died During Year:*
1939:	9,991	2,081	626	70	263
1940:	10,422	2,112	608	68	229
1941:	10,590	2,278	640	56	263
1942:	10,365	2,147	740	70	248
1943:	9,262	2,027	815	56	194
1944:	9,115	2,004	(Figures not available until end of year.)		

Note:—While the number of certificates issued each year has increased, the numbers of licentiates shown in the first two columns has decreased the past two years, due to the war (California licentiates entering military service).

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† For editorial comment, see page 179.

The recommendations of the "Committee on Postwar Medical Service," if put into operation in California, could play havoc with the opportunities available for California physicians who are now in military services, to regain or build up new practices in California.

Your attention is called to the above because of the implications involved in the Committee's recommendations to let down the bars of medical licensure.

This letter is sent also to ask you to send us your confidential or other opinion on whether you think changes in licensure as proposed, are needed, or are desirable for California.

The matter is sufficiently important to be worthy of careful consideration by the constituted authorities of the California Medical Association.

An expression of opinion by yourself will be much appreciated.

Respectfully submitted,

Philip K. Gilman,
Chairman of C.M.A. Council.
George H. Kress,
Secretary of C.M.A. Council.

Excerpts from Letters in Reply: Re Proposed Licensure Amendments

"I am opposed to the addition of the amendment to the Medical Practice Act of the State of California, for the temporary licensure of returning medical officers:

"(1) It is quite unnecessary, for each applicant is already licensed in at least one State, which is, most probably, the State of his choice.

"(2) A temporary license would be a false security to the practitioner unless he proceeded at once to obtain his State license in the regular way, and succeeded in passing the examinations. Suppose he should fail!

"(3) Since California, we believe, has more attractions for the newly fledged or location-seeking doctor, the increase in our medical personnel might be out of all proportion to our needs, and would therefore injure many and help but few. The number of physicians already licensed in California is more than adequate for peacetime service.

"(4) Such legislation might justly be interpreted as one more danger of the losing of State rights, and might, with a little manipulation, transform State licensure into Federal.

"(5) It would work an injustice on those states which have succeeded in passing a Basic Science law, to have it set aside, even 'temporarily.'

"(6) Pressure groups would probably try, and might even succeed, in changing this temporary license into a permanent one later, which would be unfair to the public, and to the California profession.

"(7) We can, and will, do everything possible for our returning medical officers, but it is unnecessary to set aside, even temporarily, existing and well seasoned laws in order to accomplish our good deeds or express our kindest wishes."

* * *

"I believe that the licensure laws should not be relaxed. We would have a flood of out-of-state doctors to compete with, but that is not so important as is the fact that standard of practice would be materially lowered and this would make for poorer medical care to the public."

* * *

"The California State Board of Medical Examiners has gone on record strongly against the issuance of temporary licenses because it was felt that this is a pernicious practice, especially in view of the fact that Doctors, who have left this State to enter the armed forces, will eventually return and will find themselves confronted with the necessity of reëstablishing their former practice.

"It is not at all impossible that some of those temporarily licensed would make a very strong attempt to have such type of license continued on the basis of having rendered good service to the community to which they had been sent temporarily. The Board feels and has felt that such a step would be a decided lowering of standards and furthermore, a grave injustice to those who have left the various communities in this State, after practicing for many years, to enter the armed forces of our country. As you are aware, no temporary licenses or special permits have been issued in California."

* * *

"I am opposed to any weakening of the Medical Practice Act as it relates to licensure.

"A temporary relaxation would be used as an argument for permanent change, to the detriment of the physicians and the public."

* * *

"To impose such a revision of the law in California would bring a real hardship on the doctors returning to California. We would find a similar condition as after the last war and will see again even without such change —viz, a large number of doctors desiring to locate in California because of the favorable climatic conditions. If the bars were let down with no examination required this would bring an even larger number of physicians to California.

"I have no figures to prove this, but my impression is that already there have been a large number of doctors come to California since the war started because of the favorable climatic conditions, and now, because the opportunity was great to reëstablish themselves rapidly in an active practice.

"I would be opposed to such change in the law because I believe the returning men would find a more difficult time in reëstablishing themselves. Certainly, first rights belong to our own men. I believe that the medical men will be very slow in being discharged and if our own men were among those discharged late, it would be another unfair advantage to the doctor from another State."

* * *

"I personally see no advantage to be gained by either the medical personnel discharged from military duty or to the community that he proposes to serve on a temporary basis. It will fill up the communities for the men who originally left them and who, until proved otherwise, we must assume wish to return there.

"I also feel that tampering with the medical licensure for California or any other State is a move toward breaking down safeguards that we have been so many years in building up.

"Personally, I am not in favor of the recommendation of the Committee on Postwar Medical Service."

* * *

"I do not think that the proposed changes in medical licensure are logical, necessary or desirable in California."

* * *

"I am opposed to this type of legislation because:

"(1) Our first obligation is to the men who are now in Service.

"(2) Dismissals from the Service will not be as rapid as many people think.

"(3) The men at home have done a good job.

"(4) Many M.D.'s who, in years past, have thought of coming to California and have now had the opportunity to *see* the State will now *want* to settle in California.

"(5) California could be filled with refugee M.D.'s the minute the bars are let down—(once in—try to get them out!). They should go back to the place from whence they came, as they are needed there. They could undermine what we now have and destroy the chances of our own doctors if and when they return to Civilian practice.

"(6) I shall vote *No* to any bill favoring such legislation."

* * *

"As a matter of principle I am opposed to the granting of licenses which would permit men to practice medicine in the State of California without any sort of an examination. In an emergency this might be permitted on a purely temporary basis, provided such licensure is granted an individual doctor to fill a specific appointment which will in no way interfere with the work of another physician who has been qualified for the practice of medicine in California by examination. . . .

"Whatever is done should in no way interfere with the professional practices of those who are legally licensed in the State and are now in practice and of those who are similarly licensed, but are now on military duty, when they return from military service to civilian practice."

* * *

"The proposed changes in licensure for doctors leaving military service to me is unnecessary. These doctors are already licensed in their respective States and we have already set up the machinery by which doctors can receive reciprocity in other States and to short cut this legislation which has been years in growing would do a considerable harm although it seems, on the face of it, that these physicians who have been in the service and are honorably discharged and are in good moral character, etc., should be permitted to practice anywhere inasmuch as theoretically they have represented their Federal Government in the military service. It is also true that these physicians have also elected to practice in certain States and should not be permitted to change their localities merely by virtue of the fact that they have been in the military service. As we all know the California Board of Medical Examiners possesses power to grant licenses in this State with a liberal hand if they so desire.

"It would be taking a good deal on the shoulders of this Postwar Committee if it should recommend that each individual State level its recommendation and requirements down to that of the States which require a standard possibly considerably less exacting than the States in which this returning physician would like to practice.

"I, for one, am for permitting existing reciprocity rules to prevail after the service of the military doctor is completed."

* * *

"I fail to see any reason for a change in our present Licensure System."

* * *

"The phrase in sentence 2 beginning "or has rendered medical service during the period 1940 to 1945 in industry or in a civilian community" seems to me to open the doors to any and all comers. This is very ambiguous and could start some very prolonged law suits to force issuance of license.

"Another fault, as I see it, is that the license could be issued for any period of time desired by the board, even for 99 years. Some such period as 6 months or a definite period for exceeding, say, 1 year would be better. This would require rehearing of every case periodically and automatically.

"I cannot see the need of this act in California."

* * *

"We, in ———, have been feeling for some time that too many new and entirely outside men are taking advantage of the war conditions to move from the places in which they have practiced to more desirable locations.

"If there is a real shortage in a new location there would be no objection. However, in a place like ———, it is now easier for them to get started than normally, but they will make it exceedingly difficult for our own men who are in the service to reëstablish themselves if this situation is allowed to continue.

"There will no doubt be medical discharges of doctors who would take advantage of this situation to come to a desirable community, rather than returning to their former homes.

"I am opposed to letting down the bars, as I feel we should give our own men as much protection as possible."

* * *

"I would think this measure would be best settled by the local State situation rather than on a National basis. At best, such States as California where there was, before the War, a higher ratio of M.D.'s to population, would be opposed to such a procedure. However, in States where such a ratio was low, this might be one method to effect a better distribution of doctors.

"I do not favor any changes in licensure of this State at this time."

* * *

"I can say personally that I would not favor any letting down in the requirements. There has been quite a large number of applicants for oral examinations in the last two years, and the Board has tried to maintain the standard already established. I am not in sympathy with any of the recommendations of the Committee on Postwar Medical Service.

"You do not need to treat this letter as confidential. I am willing to be quoted.

"I am not in favor of any temporary license being issued."

* * *

"Judging from the number of physicians applying for and receiving licenses by reciprocity to practice in California, it would appear to me that there is no need for any amendment to the Medical Practice Act of this State by which an applicant may receive a temporary license without examination. It is also understood that temporary licensure has a strong tendency to become permanent.

"It would appear to me, personally, that any form of temporary licensure would be an open invitation to a large number of physicians of whom many would be illy equipped educationally, professionally, mentally and morally, to come to California to practice medicine.

"The advertising campaigns of a number of California communities have so strongly stressed our salubrious climate and the natural beauties, resources and wealth of our State that a large number of physicians practicing elsewhere have become very eager to come here.

"I believe that the resolution of the Committee on Postwar Medical Service, with regard to the above quoted amendment, should be vigorously opposed by all California medical organizations."

* * *

"I would not like to see any changes at the present time in our method of licensing physicians. Physicians from other States wishing to locate in California and now in the armed services would probably in most instances be able to secure reciprocity from our examining board. Moreover, the physicians returning from the services are probably needed in their own communities and I do not see any reason why we should invite them to locate in California."

* * *

"As a member of the California Medical Association, it is my feeling that the California law as it now stands in regards to licensure of M.D. physicians and surgeons both as to written examinations and reciprocity, is, unquestionably, the best for the State. I am rather apprehensive that if the bars should be let down, every doctor in the nation, who could possibly make it, would want to practice in California.

"Our reciprocity law, requiring no examination for graduates who have not been out of school for more than 10 years, grants direct reciprocity. This means that, from the time they have made satisfactory application to the Board and passed the committee on credentials and which has been ratified by the Board, they receive their license within about 2 weeks' time. I do not see any need of any temporary license being granted for this reason.

"Graduates that have been out more than 10 years certainly should continue to be examined by oral examination in order to determine their fitness to practice in a fast moving state like ours. I believe it would be a very sad mistake to allow physicians to practice, whose ability is not sufficient to enable them to pass a rather lenient oral test. It certainly would be very unsafe for the people at large in this State."

* * *

"I think it would be a mistake to oppose the resolutions adopted by the Committee on Postwar Medical Service for these reasons:

"(1) It is not mandatory for a state board to grant licensure under the conditions set forth in the proposed amendment.

"(2) Opposition to the resolution would be interpreted as pure selfishness and obstructionism.

"(3) The Governor can and almost surely would, on recommendation of the Board of Medical Examiners, terminate the action of the amendment when the first few postwar years have passed.

"I dislike the phrase 'or has rendered medical service during the period 1940 to 1945 in industry or a civilian community,' since this phrase admits practically everyone to licensure without examination."

Bushfield Osteopathic Amendment to H.R. 4278

Congressional action has now been completed on the Department of Agriculture Organic Act of 1944, H.R. 4278. This bill provides for the control and eradication of certain animal and plant pests and diseases, etc.

The Senate Committee on Agriculture and Forestry, in reporting the bill April 21, added to Title III a new section, section 303, relating generally to rural rehabilitation measures. When the bill was considered on the floor of the Senate, May 2, Senator Bushfield, South Dakota, offered and the Senate accepted the following amendment to section 303:

> "*Provided,* That no part of such sums be available for the promotion or aid of any program of medical care which prevents the patient from having the services of any practitioner of his own choice so long as State laws are complied with."

The purpose of this provision was to permit participation by sectarian healers in the medical programs sponsored by the Farm Security Administration. It was, according to information available, sponsored by the osteopaths. The conference report on the bill modified the Bushfield amendment by adding this exception:

> "except that this provision [the Bushfield amendment] shall not be applicable to the promotion or aid of a program of medical care where a majority of the participants within the program group elect to confine their choice of practitioners to a list of available licensed practitioners selected by them."

This modification was unsatisfactory to Senator Bushfield who described it as "completely emasculating the amendment which the Senate had previously adopted." There were other matters in the bill that caused disagreement between the House and the Senate, including a Senate amendment relating to the school lunch program. This disagreement threatened to result in a stalemate and to prevent the enactment of other parts of the bill not in disagreement. To obviate the possibility of this stalemate, Senator Russell, of Georgia, who had charge of the bill on the floor of the Senate, offered a motion, September 5, that the Senate recede from all amendments it had made to the bill, including section 303 of Title III to which was attached the Bushfield amendment. This motion came before the Senate on September 8 and after a short debate prevailed. The Bushfield amendment was thereby eliminated in its entirety.

Labor Parley Plans Go to Congress

Seven resolutions on social security and kindred subjects adopted by the International Labor Conference in Philadelphia last May were transmitted to Congress on August 22, by President Roosevelt. He said they might prove valuable in current "consideration of problems of demobilization, reconversion of industry, employment and social security."

Roosevelt added in a special message that he may have occasion later to "direct further attention to specific provisions of these recommendations and to suggest what action by the Congress on these recommendations may be advisable."

The Chief Executive recalled that employers and workers as well as governments were represented at the conference and that the recommendations were adopted by large majorities. They embraced income security, medical care for persons discharged from the armed forces, minimum standards of social policy in dependent territories, employment organization in the transition from war to peace, employment service and national planning of public works.

Labor Unions Urge Law for All Hospitals

Vallejo Central Labor Council, on September 4, passed a resolution urging the Solano County Board of Supervisors to pass an ordinance requiring all hospitals in the county to admit any and every patient for emergency treatment on the penalty of committing a misdemeanor should treatment be refused.

The council also voted to secure legal advice on the matter and to have a model ordinance drawn up for presentation to the board of supervisors.

Under general terms of the proposed ordinance every hospital would be required to admit emergency patients for treatment or surgery, if in the opinion of the physician the health or life of the patient would be placed in jeopardy should care be refused.

Patients subsequently found able to pay for such services would be required to do so and the bills for persons unable to pay would be borne by the county.

Congress Begins Election Recess

Congress voted to recess on September 21, until Tuesday, November 14—a week after the national elections.

Many members began leaving the Capital, homeward bound to put a whirlwind finish on their political campaigns, soon after the House concurred in the Senate's adjournment resolution.—San Francisco *Call-Bulletin,* September 21.

Medical Care Is Asked for Federal Employees

Manpower Commissioner Paul V. McNutt urged Congress, on August 21, to pass legislation providing medical examinations, preventive services and emergency medical care for federal employees.

COMMITTEE ON INDUSTRIAL PRACTICE

California Industrial Accident Resolution of July 18, 1944: Re Surcharge of 15%

Re: Increase of Fees.

(COPY)

CALIFORNIA MEDICAL ASSOCIATION
San Francisco 8, July 29, 1944.

To the Members of the
California Medical Association:

It is indeed a pleasure to be able to report that some progressive action has finally been taken in the matter of medical and surgical fees for services performed under the Workmen's Compensation Act.

You will remember that late in 1942 the Association asked the Industrial Accident Commission of the State of California to approve a proposed schedule of medical and surgical fees for some 547 procedures which might be undertaken in compensation work. This proposed schedule was sent to you some months ago, together with a request that you sign a pledge card signifying your agreement to abide by the minimum fees of the schedule and to comply with the Principles of Ethics relating to compensation practice.

Our proposed fee schedule has been under advisement by the Industrial Accident Commission for more than 18 months now. It has not yet been approved but *a surcharge of 15 per cent over the existing fees has been approved, effective Aug. 1, 1944.*

A copy of the Commission's order setting up this surcharge is enclosed. You will note that it provides:

1. That the surcharge shall be effective for the "Duration," which is defined to mean six months after the cessation of hostilities.
2. That cases under treatment before and after August 1, 1944, shall have their medical and surgical charges segregated, so that services rendered before August 1, 1944, shall be charged at the existing rates and services rendered after August 1 shall be billed at existing rates *plus the 15 per cent surcharge.*
3. That the Commission proposes to establish a Study Committee to consider "a permanent medical fee schedule to become effective after the 'Duration.'"

There is a tremendous amount of inertia and indifference to the medical profession's rights, built up and due no doubt to the fact that everyone concerned, including the profession, allowed an inadequate fee schedule to remain in effect for over twenty years. However, the C.M.A. committee which has been following this matter feels that the Commission's order is as much progress as can be expected at this time and that the members of the Association handling compensation cases should abide by the terms of the Commission's order. Efforts toward establishing a more permanent and more equitable fee schedule will be continued without delay.

Fraternally yours,

PHILIP K. GILMAN, M.D.,
Chairman of the Council.

* * *

(COPY)

State of California
Department of Industrial Relations
INDUSTRIAL ACCIDENT COMMISSION
State Building, San Francisco 2.

Copy of Resolution Adopted by the Members of the Industrial Accident Commission in Meeting Assembled July 18, 1944.

WHEREAS, In recognition of the increased cost involved in the furnishing of medical services under present wartime conditions, an overwhelming majority of the insurance carriers and self-insured employers have voluntarily agreed with the California Industrial Accident Commission to pay a 15 per cent surcharge on all fees covered under the existing California Medical Fee Schedule; therefore be it

Resolved, That the Industrial Accident Commission does hereby authorize this surcharge, which is to be effective as to all medical and related services rendered under the provisions of the California Workmen's Compensation laws on and after August 1, 1944, same to continue for the duration of the war. "Duration" is defined as extending until six months after the cessation of all hostilities in which the United States is now engaged; further

Resolved, The term "medical, and related services" shall include x-ray, laboratory and physiotherapeutic services, whether furnished by practicing physicians, laboratories or hospitals; further

Resolved, Medical charges on cases presently under treatment shall be segregated so that services furnished prior to August 1, 1944, will be charged for on the basis of the then existing medical fee schedule, and the surcharge of 15 per cent shall be applied only to treatments and services on and after that date; further

Resolved, That the Commission hereby declares its intention to ask the various parties at interest—the medical fraternity, self-insurer, insurance carriers and the appropriate State Departments—to form a Study Committee for the purpose of collaborating on a permanent medical fee schedule to become effective after the "duration." (For editorial comment, see p. 182.)

COMMITTEE ON POSTGRADUATE ACTIVITIES

Research Study Club of Los Angeles (Eye, Ear, Nose, Throat)

The Research Study Club of Los Angeles announces its Fourteenth Annual Mid-winter Post-graduate Clinical Convention in Ophthalmology and Otolaryngology, January 22 to February 2, 1945. Also, a special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck," to be given February 2, 3, 4, 5, and 6, inclusive.

Providing there are at least fifty applicants, the American Board of Ophthalmology will conduct an examination in Los Angeles in January, 1945, *just before* our Midwinter Clinical Convention. Those who wish to take this examination should apply promptly to the "American Board of Ophthalmology, Cape Cottage, Maine."

Similarly, the American Board of Otolaryngology may conduct an examination (in Los Angeles) in February, 1945, immediately following our Cadaver Course. Those who wish to take this examination should apply promptly to the Secretary of this Board, Dr. Dean M. Lierle, Iowa City, Iowa.

If a sufficient number of applications for these Board Examinations are *promptly* received, it will then be possible for us to invite certain of the Board members to take part in our Clinical Convention program. To date, our guest speakers include: For the Eye—Dr. Cecil S. O'Brien and Dr. Kenneth C. Swan, of Iowa City, Iowa; Dr. William Henry Crisp of Denver, Colorado, and Irving B. Lueck, B.S., of Rochester, New York. For the Ear, Nose and Throat—Dr. John J. Shea of Memphis, Tennessee; Dr. Hans Brunner of Chicago, Illinois; Dr. Guy L. Boyden of Portland, Oregon; Dr. Chauncey D.

Leake University of Texas; Vern O. Knudsen, Ph.D., University of California, Los Angeles, and Scott Reger, Ph.D., of Iowa City, Iowa.

At the Convention held last January, the large attendance caused some anxiety. In the Didactic Course an unlimited number can be accommodated; but it is clear that we must make some elaborate preparations for the Instruction Courses. From 31 States and Canada over 300 attended, and about 100 more would have been with us if it had not been for inability to secure either transportation from many parts of the country, or housing in Los Angeles.

Arrangements have been made to permit registration by mail. The fee for the Clinical Course is $50.00, and when you apply to take the Course you can send the $50.00 to Pierre Violé, M.D., 1930 Wilshire Boulevard, Los Angeles 5, California.

As in the past, the first week is devoted largely to the Eye, and the second week to the Ear, Nose and Throat. Those who confine their work to only one of the specialties may complete most of the subjects in one week.

The fee for the Clinical Convention is $50.00; those in Military Service will be guests. The fee for the Cadaver Course is $50.00; those in the Service may enroll for this course for one-half of the regular fee—namely $25.00.

At long last, the Research Study Club of Los Angeles is beginning to accumulate some money. Beginning in a modest way, the Club wants to endow research work in various localities, publish results and send without charge monographs and books to each member. Suggestions are invited.

San Francisco Heart Committee—October Meetings

Dr. Chester S. Keefer of Boston will be one of the speakers at the San Francisco Heart Committee's Fifteenth Annual Postgraduate Symposium on Heart Disease which will be held this year October 26, 27, and 28. Other guest speakers will be Dr. Maxwell M. Wintrobe, Professor of Medicine, Utah University Medical School, Dr. S. J. McLendon of San Diego, Dr. William Gordon of the United States Public Health Service, and others to be announced later. More than twenty San Francisco physicians especially interested in cardiovascular disease will participate in the Symposium. Rheumatic fever will receive special emphasis this year.

The sessions will open Thursday, October 26, at the University of California School of Medicine. The program for Friday, October 27, will be presented at Stanford University School of Medicine and at the San Francisco Hospital. A dinner meeting has been arranged for the evening of the 27th at the St. Francis Hotel. Saturday morning's program will be held in the Auditorium of the Nurses' Home of Mt. Zion Hospital.

Complete printed programs will be available soon. Registrations and hotel reservations may be made through the secretary of the San Francisco Heart Committee at 604 Mission Street, San Francisco 5. Physicians in military service are invited without payment of a registration fee.

Physicians are urged to register in advance if possible.

Another Health Center in Los Angeles City

Tentative arrangements for architectural services in connection with the health center planned for 49th Street and Avalon Boulevard have been recommended to the City Council by the Board of Public Works, subject to an allotment of $300,000 requested for the project from the Federal Government.

The application provides for construction of a $200,000 building, for which the city is to provide $70,000 in addition to $65,000 for the site, equipment, architectural and engineering expenses.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

American Hospital Association: 46th Annual Conference

The necessity for vastly expanded facilities to treat mentally disabled patients now and in postwar years will lend special significance to the consideration of mental hospitals and techniques at the 46th annual convention of the American Hospital Association, was held at the civic auditorium in Cleveland, Ohio, during the first week in October, the third wartime conference of the Association, a nonprofit corporation composed of hospitals in almost every city in the United States.

Recognizing the necessity for fully satisfying the health needs of their communities, the more than 3,000 member institutions of the American Hospital Association are taking great interest in the hospital construction and postwar planning discussions.

The American Hospital Association, through its member institutions and allied professional groups, was organized in 1899 to promote the welfare of the people through the development of hospital and outpatient service. . . . According to a survey of 1,663 hospitals conducted by the Association's Council on Government Relations under John N. Hatfield of Philadelphia, postwar hospital construction may reach $1,193,133,000 and provide 180,626 new hospital beds. This will increase the national hospital bed count to 1,829,880, or, one for every 71 persons in America.

Almost three-fourths of the reporting hospitals revealed some building plans.

Hospitals now represent an investment of six billion dollars. After the war, nonfederal hospitals of the general and allied types plan to invest approximately $177,000,000 on new construction, including $12,880,000 on rehabilitation, $3,400,000 on re-equipment, and $13,133,000 for new equipment.

Financing for this program will be carried out largely with government help under the Lanham Act or through public subscription. A number of hospitals plan on private finance, normal hospital income, or cash already on hand.

Future Hospital as Seen by Surgeon General Parran, U.S.P.H.S.

The post-war aim of the American people should be a national health program which guarantees the best of health and medical care for the entire population, Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, said in San Francisco on September 4.

Dr. Parran delivered the principal address at the Labor Day dedication ceremony for the new U. S. Cadet Nurse Corps residence at the University of California School of Nursing in San Francisco.

"Public health, which means the sum total of individual health, is of paramount public concern," he said. "Working together, the public and the health and medical professions can attain the democratic goal of an equal opportunity for health among all people.

"The hospital of the future should be an instrument of total community health, with facilities and skills necessary to promote health and prevent disease as well as to treat the sick."

PROPOSED PLAN

He proposed a national health program which would include adequate inter-related and equitably distributed hospital and medical service. It would be operated locally through grants-in-aid and would be sufficiently diversified to meet the needs of the individual States. It would be publicly supported through insurance, taxation, or a combination of both.

San Diego Venereal Disease Center for Women

Except for inconspicuous treatment rooms and laboratory, San Diego's newest project aimed at eradication of venereal disease might well be mistaken for a women's dormitory containing such extra facilities as a recreation room, indoor and outdoor play space, and spic-and-span kitchen and dining room.

Known as Harbor View Hospital, the recently opened institution at Kettner Boulevard and Market Street, already has cured more than a score of its patients in a rapid treatment technique under guidance of Dr. Raleigh Burlingame, director; Dr. Leonard I. Lesser, U. S. Public Health Service assistant surgeon, and Miss Evelyn Binkley, supervising nurse.

SOME VOLUNTARY PATIENTS

Although 80 per cent of the cases to date have been women referred by the city jail following arrest on vagrancy charges, numerous patients have sought the treatment after clearing through the city-county health department out-patient clinic at the Civic Center, according to Burlingame.

Treatment consists of injection of penicillin at three-hour intervals over a 24-hour period, when sulfa drugs prove ineffective. If the culture shows a negative reaction, hospital attendants allow a week to elapse before taking another culture. A second negative showing is followed by a third culture 48 hours later before the patient is discharged.

"Those who opposed the center when it was being discussed contended that we would have a hopeless task of rehabilitation," declared Armistead Carter, president of the Social Hygiene Association, which backed efforts to establish the hospital. "But i.q. tests of the girls admitted have shown them to have fairly high intelligence. If the hospital can restore the health and spirit of these girls, it will more than adequately serve its purpose."

The city council appropriated $35,000 to launch the project, with the expectation of reimbursement from the Federal Government, which to date has appropriated approximately $25,000, with more funds due.

Many Kept Out of Hospitals by Bed Shortage

"Los Angeles hospitals have a current shortage of approximately 4000 beds and hundreds of persons are being turned away every week because beds are lacking for their care," J. Howard Ziemann declared on August 29, at the initial meeting of the new board of directors of the recently expanded United Hospital Fund of Los Angeles County at the California Club.

First steps toward working out a master hospital plan for the county to provide 1660 of the needed beds immediately and make hospital facilities conveniently available to the "self-supporting middle economic group" were taken.

T. R. Knudsen, creamery company executive, was elected organization president. Willard W. Keith, Harry G. Johansing and Ziemann were named vice-presidents; Colin M. Gair, treasurer, and Harry Cartlidge, secretary.

Named to the executive committee were L. A. Alesen, M.D., president of the Los Angeles County Medical Association; Howard Burrell, director of the California Hospital; Joseph A. Hartley of the Braun Corp., Ritz E. Heerman, superintendent of the California Lutheran Hospital and president of the Hospital Council of Southern California; Ray W. Smith, manager of the Downtown Business Men's Association; A. J. Will, superintendent of Los Angeles County Charities, and James E. Shelton. Sixteen members of the board of directors represent hospitals, 32 nonhospital organizations.

"In the week ending Aug. 30," Ziemann asserted, "eight hospitals, which are members of the fund, turned 268 persons away because they did not have beds for them."

These eight hospitals, which have a total of 2036 beds, had 6593 reservations on file when these 268 cases were rejected for lack of facilities, he explained.

"Normally hospitals should not be more than 85 per cent full, so that they will have beds for emergency cases," Ziemann pointed out. "But local hospitals are now filled to 94.2 per cent."

One local hospital, he said, was 107 per cent full, beds being in the aisles and every available space.

W. C. Mullendore, president of the Los Angeles Chamber of Commerce; Bishop Bertrand Stevens of the Episcopal Church and Msgr. Thomas J. O'Dwyer participated in the meeting.

Lanham Grant to Los Angeles County Hospital

Long Beach patients will be included in the 700 cared for in the County General Hospital in the fiscal year 1944-45, maintained through $588,000 made possible by a Lanham Act grant signed by President Roosevelt, it was announced August 31 by City Prosecutor Albert C. S. Ramsey.

A. J. Will, county superintendent of charities, said that this amount is $8000 in excess of the total amount received for the previous two years, which means that the Federal contribution towards hospitalization of families of servicemen and war workers, unable to afford private hospitalization, has been more than doubled.

Annual Session of American Hospital Association

Representatives of 3,000 hospitals in the United States and Canada met in Cleveland the week of Oct. 2 for the Third War Conference and 46th Annual Convention of the American Hospital Association.

Hospitals today are bringing comfort and new hope to the sick and the injured in every area of the world, on the battlefields, and beyond in regions of devastation. Community hospitals, too—over 6,500 of them in the United States alone—are giving magnificent service, carrying abnormal loads with staffs drained by the military services and by industry.

The needs of the citizen of the small town, the farmer, the child, and the mental patient, as well as of those served by large general hospitals, were considered in a discussion of the small hospital, public hospitals, children's and mental hospitals.

Volunteer workers have come to play a great part in keeping today's hospital in action. With 52,000 doctors and 50,000 nurses in the armed forces, volunteers have filled rôles from office workers to kitchen assistants to nurses' aides. Dr. Anthony J. J. Rourke, medical director of Leland Stanford University Hospitals in San Francisco, spoke on this subject on Tuesday, October 3.

Internes Granted Salary Increase

On September 5, salaries of internes at the Los Angeles County General Hospital were boosted from $40 a month to $60 a month with room and board by the County Supervisors.

Need Candidates for Home Nursing

Five thousand candidates for home nursing certificates must enroll with the Los Angeles Chapter, American Red Cross, if the quota for the year is to be met, it was announced on September 6. Since January 2900 certificates have been issued.

Dr. Lowell S. Goin, president of the California Medical Association, urged all women to enroll for the course, pointing out that this training enables women at home to relieve the pressure on civilian doctors and nurses by giving intelligent care to members of their families who may be ill.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Bubonic Plague

(California's Experiences with the Disease)

"Unknown to most Americans, bubonic plague, the dread Black Death of the Middle Ages, is today entrenched in the United States. The disease has a firm foothold in the Western states and is now spreading eastward into the Mississippi Valley. . . .

"In the United States, however, the plague has taken a new and potentially even more dangerous form, for it is spread by wild rodents such as squirrels, rabbits, chipmunks, prairie dogs, etc. It has also been discovered in burrowing owls (which share the holes of prairie dogs) and hawks. . . .

"Wild rodent plague follows no such cycle; it is everlasting and permanent. Americans will have to learn to live with the plague," warns the nation's foremost plague expert, Dr. Karl F. Meyer of the University of California. And, he adds, the fact that the United States has so far escaped a catastrophic plague epidemic does not indicate that one may not occur some time . . .

"In the United States the first bacteriologically proved case of plague was discovered in 1900 in San Francisco, though experts think that sporadic cases had existed for several years in North America. . . .

"Then followed one of the most shameful episodes in the history of American public health. San Francisco's business interests and all its newspapers except one flatly denied that the plague existed there. So did California's Governor. So did a group of prominent San Francisco doctors*. . . . (The rôle of rats and fleas in spreading bubonic plague was not discovered until 1904.) . . .

"The handful of physicians who found the plague in San Francisco were personally vilified and bitterly ridiculed in the press. Businessmen censured them as "meddlesome doctors seeking publicity." As a reward for finding plague bacteria, a state bacteriologist was not only discharged but deprived of part of his back salary. The state refused to print plague reports and statistics.

"But the statistics continued to pile up as people in San Francisco's Chinatown died regularly of this supposedly non-existent disease. In 1900 at least 121 known cases appeared, all except six of them fatal; but scores of other cases were unrecognized, concealed by the victim's friends or hushed up by frightened officials. The plague controversy became so violent that President McKinley appointed a commission to dig into the facts. The commission agreed that plague had invaded the city. All of Chinatown was quarantined, and surrounded by ropes and policemen. In 1901, when the plague petered out, many people still believed it had never existed.

"The plague appeared again after the San Francisco fire in 1907. Rats fleeing from Chinatown spread the disease to every quarter of the city. Within six months the incidence of plague among rats tripled. But again business interests and newspapers refused to recognize the epidemic. At last the Federal Government threatened to quarantine the whole city. A public health officer called a meeting of prominent businessmen. 'Probably you do not realize what such a quarantine means,' he said. "It means that each man in this room, and you are all millionaires, will go broke!' The threat of bankruptcy worked better than the threat of the Black Death. Businesses and the local government reluctantly coöperated to suppress the rats rather than the facts.

"Then health officials made the most tragic discovery of all. Sometime during the years when San Francisco was denying that it harbored the plague, the disease had somehow crossed the bay and infected the ground squirrels in the region south of the Sacramento River. The State began a campaign to exterminate the infected animals. Squirrels were slaughtered until the disease seemed to be almost wiped out among them and by 1920 the antiplague campaign was dropped.

"For a while the plague lay dormant, then in 1933 and 1934 four people died of it. Federal investigators found that California's ground squirrels and other rodents were still widely infected. Then they made the alarming discovery that Oregon, Montana and other states had also been invaded.

"Forty years ago the plague could probably have been driven completely from the United States. Now it is much too late. Too many animals over too wide a territory are infected. Continuous sentry duty against the plague is maintained by the U. S. Public Health Service and several state health departments. Plague hunters regularly scour the West, shooting squirrels, trapping rabbits, digging dead gophers from their burrows. With gloved hands they carefully put their catches into flea-proof bags and take them to their laboratory trucks. There they comb the fleas from the animals and cut out certain organs and tissues. These specimens are sent to the U. S. Public Health Service laboratories at San Francisco, where bacteriologists cautiously examine them for *Bacillus pestis*, the bacteria which cause plague. . . .

"Regions found to be infected with the Black Death are posted with warnings that "sylvatic plague" is present and that residents and visitors should avoid contact with rodents. These warnings are often misunderstood, since not everyone realizes that sylvatic plague is identical with bubonic plague except for the sort of animals which carry it—a distinction important chiefly to epidemiologists. . . .

"Besides its bubonic form, characterized by buboes or swollen lymph glands, usually in the groin, the plague may appear in two other forms, both caused by the same bacteria. These are even harder to identify. One is septicemic plague, in which the bacteria invade the blood stream. The other is pneumonic plague, in which the lungs are the center of infection. The latter is not only the most difficult form of plague to diagnose, since it resembles commoner respiratory diseases, but it is also the most menacing, since it is the only form of plague which can spread without the help of fleas. The victim's breath floods the air with bacteria-filled water droplets which may infect anyone in their path, and a major human epidemic could thus begin without rat carriers. A preview of such a disaster appeared in Oakland, California, in 1919 when an improperly diagnosed case of plague began a series of thirteen cases, all but one of them fatal. Again, in Los Angeles in 1924, an epidemic of pneumonic plague killed thirty out of thirty-two sufferers." . . .—From an article on "Bubonic Plague in America," by Tom S. Hyland in "The American Mercury" for September, 1944.

Northern California Union Health Committee

(Excerpts from Its "News Letter" of September 18, 1944)

Labor Answers Our Plea.—As a result of our appeal to labor unions to support us financially as well as by interest and activity, last week we were notified that:

The Executive Board of the Brotherhood of Locomotive Firemen and Enginemen voted to contribute $120 per year to the committee's activities as long as we are in existence.

The A.F.L. Piledrivers' Local 34 membership voted to make a monthly donation of $10 per month.

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* For editorial comment and other references, see p. 183.

The A.F.L. Miscellaneous Workers' Local 110 membership voted unanimously to earmark $150 of their contribution to the War Chest fund for this committee.

That's what we call coöperation.

Young Physicians Want Group Practice.—In returns to a questionnaire distributed by the American Medical Association's Committee on Postwar Medical Service, a majority of physicians now in uniform answered "Yes" to the question of whether or not they would like to become "associated in private practice" with an organized group of physicians. The figure is 54 per cent among the youngest men and 57 per cent in the 35-42 group. This makes it clear that many of our young doctors recognize, through practical demonstration, the trends within medicine which make solo practice no longer either the best or the most economical kind of service for the physician or for the patient. Adjustments between general and specialty practice, moreover, can be worked out within a well-organized group of physicians, since they can readily eliminate the competitive financial tensions among doctors and gaps in service for patients which too often debilitate solo practice today.

C.I.O. Resolutions on Health and Safety.—The State C.I.O. Convention, which met in Los Angeles two weeks ago, makes the following proposals for solution of the most pressing health and medical care problems: 1) Empowering the Surgeon General, with provision of the necessary funds, to commission physicians into the U.S.P.H.S. to be sent to critical areas; 2) Provision by the Veterans' Administration of all necessary medical care and attendant services to all honorably discharged servicemen and women; 3) Enactment of the Wagner-Murray-Dingell Bill, amended to apply to Federal Workers also, to provide an adequate medical plan for the whole population and planned distribution of doctors in metropolitan and rural areas; 4) adequate representation of labor, industry, and the general public in the Procurement and Assignment Service of the War Manpower Commission and in the Veterans' Administration, as well as all other governmental agencies dealing with medical care.

Labor Will Testify at Pepper Hearings.—The Senate Subcommittee on Wartime Health and Education is continuing its hearings on the nation's health, September 17-20. Causes underlying the rejection by Selective Service of nearly 5 million young men for physical and mental reasons will be investigated. Key witnesses will present their proposals as to how to insure the future physical fitness of the nation. Officials of the A.M.A. will have an opportunity to air their views, but it is expected that significant testimony will also be forthcoming from labor. Representing the A.F.L. will be William Green and Robert Watt; from the C.I.O., Philip Murray and U.A.W. Secretary George Addes.

West Coast problems, together with California's long experience with various prepaid medical care plans, were recognized by the invitation extended to both representatives of C.P.S. and labor. Albee Slade, Legislative Director of the L. A. Industrial Union Council, will represent the C.I.O. for California. The N.C.U.H.C. will get a full report of the proceedings from Albee when he returns from Washington and will keep its readers informed.

Symposium on National Medical Care.—Worth noting are these comments of management and public officials on the attainment of health through broadened social security and the development of federally aided programs:

Henry J. Kaiser made this statement in a speech before the United Steel Workers of America last May: "Every worker in America should be able to buy the best in medical service in advance, pay for it on an insurance basis, and enjoy to the full sense of independence which will flow from such action. In the vast majority of instances, the hospitals and clinical facilities should be provided by industry; but where this is not possible the government should lend the required funds to enterprise or to individuals who are willing to undertake the responsibilities of organization."

Senator Claude Pepper, in his recent West Coast conferences with medical and labor representatives in Southern California and in San Francisco with the staff of N.C.U.H.C. and Dave Jenkins, member of our Board, indicated that, while we may be a long time in getting a national system of health insurance, the granting of funds to assist existing and rapidly-developing prepayment plans, and to finance a more adequate hospital system is a likely possibility for the immediate postwar period. To assure the best policy in medical and hospital care plans, labor, along with other representatives of the public will want to have a voice in the administration of local plans.

Surgeon General Parran, U.S.P.H.S., in his September 4 speech at the University of California Medical Center, paid tribute to labor and recognized the workers' stake in the nation's health program with this statement: "It is not generally recognized that the labor movement, which has resulted in shorter hours of work, better wages and working conditions, abolition of child labor, and better food and housing for workers' families, has been a powerful factor in raising levels of the national health. Labor, directly and indirectly, has a big stake in the future National health program. Conversely, any sound National health program must be within a dynamic economic system which provides for labor full and fair employment.

"The health program we seek will assure the best of health and medical care to workers and their families as a part of the entire population. It also will create jobs. If we are to provide adequate health care for all our people, many hospitals must be erected and maintained."

Surgeon General Parran proposes an integrated hospital system at the center of which would be the teaching and research facilities, and, in the remote areas, health centers, "the field stations of the future system of public health and medical care." Apparently, the distinction between public and private health is rapidly disappearing.

Parran, too, pointed to the fact that our tremendous needs for more hospitals, medical personnel better distributed, and for spreading the risks of expenditures for illness demand federal subsidy. He added that "each community would be given maximum opportunity to work out its own plan, with its own resources, with assistance from the states and from the Federal Government."

National Health Program—As Proposed by Surgeon General Parran (U.S.P.H.S.)

A national health program to include adequate, interrelated and equitably distributed hospital and medical service, as well as greatly expanded preventive services, sanitary facilities and control of mass diseases, was proposed by Dr. Thomas Parran, Surgeon General, of the U. S. Public Health Service, in a Labor Day address made at the University of California Medical Center, during his recent trip to the West Coast.

Speaking at the invitation of Dr. Robert Gordon Sproul, President of the University, Doctor Parran's address was occasioned by the dedication of the new U. S. Cadet Nurse Corps Residence at the University's School of Nursing.

In detailing the proposed plan for such a National health program the Surgeon General pointed out that it would be developed gradually, would be operated locally through grants-in-aid, and would be sufficiently diversified to meet the needs of the individual States. It would be publicly supported through insurance, taxation or a combination of both.

"The health program we seek will assure the best of health and medical care to the entire population," Doctor Parran said. "Hospitals today face a broader responsibility than ever before. The hospital of the future should be an instrument of total community health, with the facilities and skills necessary to promote health and prevent disease as well as to treat the sick.

"A number of major elements go into the making of a National health program. As a first step, all available knowledge on the prevention of diseases should be applied in every community. A National health program operating efficiently in every community of the land will bring about a great reduction in the volume of illness.

"Broadened social insurance will advance National health by spreading the cost of illness. Social insurance, however, no matter how complete, does not constitute a National health program. It is only part of it, and contributory toward it.

"It is my belief that there can be evolved in this country a National health program fitted to the diverse social and economic problems throughout the forty-eight states. I do not visualize such a program as entirely socialized or an entirely private undertaking. Rather, it is a combination of both, designed to meet the needs of the American public which increasingly recognizes that a sound and healthful citizenry is essential to meet the tasks of peace no less than the emergencies of war."

State Mental Health Plan

Governor Earl Warren stated on August 31, he would call a special conference in Sacramento to draft a statewide program of therapy and preventive treatment in the field of mental health.

Nearly a score of leaders in neuropsychiatry and public health, state officials and legislators were asked to meet with the Governor on Friday, September 8.

"One of the most important health problems confronting the people of this State and nation is that of mental health," declared Warren in calling the conclave.

"Its magnitude is indicated by the fact the State has over 35,000 beds for the care of mentally ill patients and expends over nine million dollars annually for giving this custodial service," he added.

He pointed out the National Selective Service has found that well over 10 per cent of all selectees examined have been mentally unfit or defective to a degree that it has been necessary to reject them for service in the armed forces.

In addition to state officials, including heads of Department of Institutions, Social Welfare and Veterans' affairs, those expected to attend next week's conference include Dr. Karl Bowman, director of the Langley Porter Clinic; Dr. George Johnson of Stanford University; Dr. Glenn Meyer of Los Angeles and Dr. William P. Shepard, chairman of the Western Branch, U. S. Public Health Association.

New Health Service Department in Fresno

The California State Department of Public Health is establishing a district office in Fresno to serve a large San Joaquin Valley area.

Although primarily assigned to consult with and advise local health officers in Calaveras, Tuolumne, Stanislaus, Mariposa, Merced, Fresno, Tulare and Kings Counties, the staff of specialists will afford direct help whenever necessary.

Such activity, bolstering the endeavors of local agencies, makes for uniform progress throughout the state. A nine county territory will be served in this area branch.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (6)

Alameda County (4)

Dunn, Thomas B., *Oakland*
Littlefield, Ruth B., *Berkeley*
Pedemont, Leo. R., *Oakland*
Small, L. Kendall, *Oakland*

San Diego (1)

Patterson, George W., *San Diego*

San Francisco (1)

Harrison, Harry L., Jr., *San Francisco*

In Memoriam

Crease, Henry George. Died at Pismo Beach, August 15, 1944, age 76. Graduate of the Jefferson Medical College of Philadelphia, Pennsylvania, 1891. Licensed in California in 1901. Doctor Crease was a member of the Kern County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Stratton, George West. Died at Marysville, August 29, 1944, age 79. Graduate of the Missouri Medical College, St. Louis, 1888. Licensed in California in 1888. Doctor Stratton was a member of the Yuba-Sutter-Colusa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Wilmeth, Ossie Frank. Died at Oakland, August 26, 1944, age 54. Graduate of the Lincoln Medical College, Eclectic, Nebraska, 1916. Licensed in California in 1937. Doctor Wilmeth was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Hoover's Sign.—Among the teachers and practitioners who did much good work in America was Charles Franklin Hoover. He served in this capacity at the Cleveland City Hospital from 1894 to 1907, and was professor of medicine (1907-25) at the Medical College of Western Reserve University. It was during this period (1913-17) that he investigated the ventilatory functions of the diaphragm.—Warner's *Calendar.*

Hick's Sign.—There is no phase of obstetrics or gnecology that John Braxton Hicks did not enrich. Yet his reputation will probably rest for the most part upon his classical papers, especially that "On Combined Internal and External Version," and "On the Condition of the Uterus in Obstructed Labour." Hicks was also the inventor of some useful apparatus, among which was a device for moving patients.—Warner's *Calendar of Medical History.*

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† For roster of officers of component county medical societies, see in front advertising section. (To aid in war-time paper conservation, roster is printed on alternate months.)

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session will be held in New York City.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note. For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In October, KFAC will present these broadcasts on the following Saturdays: October 7, 14, 21, and 28.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Departments of the United States Army and the United States Navy, are on the air each Saturday at 1:30 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Bookward Ho!* Educational issue JAMA (August 19, 1944, Vol. 125, No. 16) always runs ads of hot medic volumes, but it misses a few: AAAS symposia, such as Aerobiology, Chemical Control of Insects, Tuberculosis and Leprosy, Malaria, Mental Health, The Cell and Protoplasm, Relapsing Fever, Fluorine and Dental Health, Surface Chemistry, and Blood Heart and Circulation (AAAS, Smithsonian Institution, Washington 25, for $3 to $4 each); various University Press publications on medicine, and medical society reports. Maybe some of these outfits should advertise in the Journal? Did you note J. S. Simmons & Co.'s *Global Epidemiology* (Lippincott, Phila., 1944, $7)? Or. R. L. Pullen & Tulane's *Medical Diagnosis* (Saunders, Phila., 1944, $10)? Or O. Glasser's & Co.'s *Physical Foundations of Radiology* (Hoeber, N. Y., 1944, $5)? Or F. C. Zapffe's series for med. students (Hoeber, N. Y., 1944, including M. Everett's *Biochemistry* & C. Thienes' *Pharmacology*)? Or K. Judovich & S. Bates' *Segmental Neuralgia in Painful Syndromes* (F. A. Davis, Phila., 1944, $5)? Or T. Gordon's *Romance of Medicine* (Davis, Phila., 1944, $5)? Or. D. Bispham's *Malaria* (Wms. & Wilkins, Balt., 1944, $3.50)? Or A. R. Rich's *Pathogenesis of Tuberculosis* (Thomas, Springfield, Ill., 1944, $10.50)? Or E. C. Rosenow's *Poliomyelitis (Internat. Bull. Med. Res.*, N.Y., 1944)? Or W. H. Gantt's *Experimental Basis for Neurotic Behavior* (Psychosomatic Med. Mon., N.Y., 1944, $4.50)? Or the 1944 *New and Non-Official Remedies* (AMA, Chicago, 1944, $1.50)? Or *Science in Soviet Russia* (Cattell Press, Lancaster, 1944, $1.50)? Or Volume Five of J. Alexander's *Colloid Chemistry* (Rheinhold, N.Y., 1944, $20)? Mimeod, but in book class are J. A. Phalen's *Blood Plasma Program* & J. J. Waring's *Spontaneous Pneumothorax* (Office Med. Info., Nat. Res. Counc., Washington, 1944, free). P. C. Bucy edits *Precentral Motor Cortex* (Univ. Illinois, Urbana, 1944), with Fulton foreword and fine contributions.

2. *Thiouracil in Toxic Goiter*: E. B. Astwood's full summary appears (*J. Clin. Endocrin.* 4:229, 1944). In clinical survey by T. H. McGavack & Co., it appears that 10 per cent of treated patients show toxic reactions (*Ibid.*, p. 249). A. H. Meyer notes granulocytopenia after recommended dosage, with recovery after stopping drug and using pentanucleatids (*Calif. West. Med.*, 61:55, 1944).

3. *Insecticides:* W. A. L. David and P. Bracey show that activation of pyrethrins in fly sprays by sesame oil, lubricating oil, or butylundecyleneamides is caused by increased persistence of droplets (*Nature*, 153:594, May 13, 1944). R. D. Lillie and M. I. Smith offer important report on toxicity of DDT (*Pub. Health Rep.*, 59:979, 984, July 28, 1944). This is amplified in issue of August 4 with notes by A. A. Nelson & Co. Health hazard involved by oral or skin absorption—no data on inhalation in fly sprays—with possible hyaline and fatty degeneration of the liver, and with nervous symptoms. Ingested thiamin is NO mosquito repellent, say C. S.

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

Wilson & Co. (*Science*, 100:147, August 18, 1944) in refutation of W. R. Shannon (*Minnesota Med.*, 26:799, 1943).

4. *Antibiotics:* S. A. Walsman & Co. demonstrate control of gram-negative infections by streptomycin (*Science*, 100:103, August 4, 1944). D. H. Rosenburg & J. C. Sylvester report penicillin rapidly penetrates meninges and that IV or IM administration should be effective in meningitis (*Science*, 100:132, August 11, 1944). J. Brunel reminds us that many others noted antibiotic action before Fleming (*Rev. Canad. Biol.*, 3:333, 1944).

5. *Thus and So:* In the July, 1944, Gastroenterology, dedicated to Ajax Carlson, appears W. Alvarez's discussion on heartburn. F. H. J. Figge & Co. show excessive porphyrin excretion by UV fluorescence and suggest relation to cancer susceptibility (*Cancer Res.*, 4:465-486, 1944). E. L. Way and L. K. Chan note low toxity and high trypanicidal action of arsenical sulfonamide (*J. Pharmacol. Exp. Therap.*, 81:278, 1944). A. Albert & Co. of Sydney note antistaphylococcal action of mapharsen (*Nature*, 153:712, June 10, 1944). J. Sacks show glucose absorption by muscle occurs by formation of hexaphosphate on cell membrane (*Amer. J. Physiol.*, 142:145, 1944). R. W. Raven describes effectiveness of dusting proflavine powder in wounds (*Lancet*, 2:73, July 15, 1944). J. H. Ridout & Co. find that alloxan causes hypoglycemia by killing islet cells, with resulting insulin leeching into blood (*Science*, 100:57, July 21, 1944). I. Aird discusses military surgery in geographical perspective (*Edin. Med. J.*, 51:184, 1944). J. F. Rinehart's ideas on salt metabolism in polio are in Naffziger volume (*J. Nerv. Ment. Dis.*, 99:825, '44).

Out-of-State M.D.s Coming to California.—Far more doctors from other states than ever before are applying for "reciprocity" California medical licenses, the State Board of Medical Examiners reported on August 29.

The Board said the increase "probably is due to the fact that many doctors in the military service wish to remain in California after the war; also many doctors in the East and Middle West are aware that over 4,000 California doctors have entered the armed service and they feel that now is an opportune time to start a practice in California and thus be established before the war ends."

Minimum Fees for Industrial Accident Work—Fee Schedules of Twenty-five Years Ago.—CALIFORNIA AND WESTERN MEDICINE, in an editorial in the June, 1920, issue of the *California State Journal of Medicine* on page 212, and entitled "New Minimum Fees for Industrial Accident Work", discusses the problem.

In the July, 1920, number of the *California State Journal of Medicine*, under the report of the C.M.A. House of Delegates, appears a lengthy report, on pages 260-264, inclusive.

Also, the minimum fee table adopted on May 11, 1920, is printed in 1920 June issue on pages 237 and 238.

Association of Military Surgeons of the United States.—The complete program for the 52nd annual meeting of the Association of Military Surgeons of the United States to be held Nov. 2-4 at the Hotel Pennsylvania, New York City, has been announced by Col. Lucius A. Salisbury, Association present.

The opening session at 10 A.M. Nov. 2 will feature addresses by Maj. Gen. Norman T. Kirk (M.C.), Surgeon General, U. S. Army; Vice Adm. Ross T. McIntire (MC), Surgeon General, U. S. Navy; Thomas Parran, (M.D.), Surgeon General, U. S. Public Health Service, and Brig. Gen. Frank T. Hines, Administrator, Veterans Administration.

A "Symposium on War Surgery," under the direction of Brig. Gen. Raymond W. Bliss, (M.C.), Chief of the Operations Service of the Army Surgeon General's Office, will take place during the afternoon of Nov. 2.

Discussion panels, which will be integrated with forum lectures and symposiums, will be held after the regular sessions on Thursday and Friday. Separate discussions led by outstanding specialists, have been arranged for medical, dental, veterinary, sanitary and medical administrative corps officers.

Other features of the meeting will be military and commercial scientific exhibits, arranged under the direction of Col. F. H. Foucar, of the Second Service Command Laboratory, Medical Motion Pictures, the Annual Banquet and special "Army" and "Navy" nights

American College of Surgeons.—The American College of Suregons, upon action of its Board of Regents, has canceled its Annual Clinical Congress because of the acute war situation that has developed, involving greater demands than at any time in the past upon our transportation systems for the carrying of wounded military personnel, troops, and war material. The Congress was to have been held in Chicago, October 24 to 27.

At the annual meeting of the Board of Regents which will be held later in the year, fellowship in the College will be conferred *in absentia* on the class of initiates of 1944, as there will be no Convocation exercises. At the same time the list of hospitals, cancer clinics, medical services in industry, hospitals, conducting programs of graduate training in surgery, and medical motion pictures, that meet the College standards, will be approved and later published.

All present Officers, Regents, Governors, and Standing Committees will continue in office.

War conditions permitting, the Clinical Congress will be held in the fall of 1945.

Psychiatric Rehabilitation Clinic.—The Department of Psychiatry of the Mount Zion Hospital of San Francisco announces the opening of a Psychiatric Rehabilitation Clinic for the treatment of ex-servicemen and women discharged from the armed forces on account of neuropsychiatric disabilities.

The Clinic will utilize both individual and group therapy and will be staffed by psychiatrists, internists, psychiatric social workers, vocational advisors, dieticians, etc. . .

The Staff will consist of Dr. J. Kasanin, Director; Dr. Emanuel Windholz, Chief Psychiatrist; and a corps of volunteer psychiatrists, psychiatric social workers, etc.

The project was made possible by a grant from the Columbia Foundation of San Francisco.

Address by Dr. Wilbur A. Sawyer, Former California State Health Director.—One of the world's best informed experts in international health is Dr. Wilbur A. Sawyer, who is now Director of Health for the United Nations Relief and Rehabilitation Administration. He has just assumed the important duties of this office following a service of a quarter of a century with the International Health Division of the Rockefeller Foundation. At the time of his retirement from the Foundation in June he was Director of the Division. Prior to his association with the Rockefeller interests he was Chief of the Division of Laboratories and finally Director of the California State Department of Public Health. He recently addressed the New York Academy of Medicine, where he presented the Hermann M. Biggs Memorial Lecture under the title, "International Health." The address is printed in *California's Health*, semi-monthly bulletin of the California State Board of Public Health, in its issue of September 15, 1944.

Los Angeles Poliomyelitis Fund.—Five months of legal interchanges ended on August 25, with the decision that the $17,265.88 collected from Los Angeles city school employees and pupils last February for infantile paralysis relief, is to be divided equally between the Harlan Shoemaker Foundation and the National Foundation for Infantile Paralysis, it was announced by the Board of Education.

Dr. Raymond E. Pollich, assistant school superintendent, in charge of such funds, said that each of the two organizations had agreed to accepting one-half of the fund collected here.

Northern California Physicians' Art Society.—With some 60 friends of the medical, art and musical worlds as guests, Dr. and Mrs. Chelsea Eaton and Dr. and Mrs. Francis H. Redewill were joint dinner hosts last night at Orinda Country club, celebrating the opening of the club's art exhibition.

This exhibit, sponsored by the Northern California Physicians' Art Society, consists of some 90 art pieces in oils, water colors, tempera, pastels and wood carvings.

Members of the society include 25 physicians in cities around the bay whose hobby is art in some form.

Among Oakland and Berkeley doctors who contributed to the exhibition were Drs. Chelsea Eaton, S. H. Babington, David Hadden, Albert Paul Krueger, F. H. Redewill and L. W. Wuesthoff.

The Northern California organization is affiliated with the national art group formed eight years ago, the American Physicians Art Association, of which Dr. Eaton is first vice-president, and Dr. Redewill, executive secretary-treasurer.—Oakland *Post-Enquirer*, September 15.

Perhaps Half of Nation Mentally Ill.—Some startling facts on the psychiatric toll of World War II were given to Huntington Park Kiwanians last Friday by Dr. D. D. Eitzen, Ph.D., noted psychologist and educator.

"Only 12 out of every 25 babies born today are destined to be 'normal' adults," Dr. Eitzen said. "Of the 25, one will be completely insane—the other 12 will be psycho-neurotics."

Reviewing the tremendous mental casualties of this war, Dr. Eitzen pointed out that from 33 to 60 per cent of all overseas casualties stem from mental breakdown and that 15 per cent of all 4-F's are emotionally undeveloped.

"However," he continued, "the war does not produce them. It precipitates them."

The alienist pointed out that this condition is a challenge to society, educators, ministers and psychologists of the nation, and urged an indulgent understanding of the problems of the returning servicemen. . . .—Huntington Park *Bulletin*, August 24.

Old Tubercular Spots Flare Up at 42,000 Foot Altitude.—Howard W. Blakeslee, Associated Press Science Editor, on September 5, reported that two doctors who voluntarily exposed themselves in the interests of science to repeated excursions into thin air at 42,000 feet developed active tuberculosis of the lungs.

This tuberculosis, as it was reported to the Aero Medical Association of the United States yesterday, was not caught directly in the altitude experiments, but was caused by thin air reopening old, long healed tubercular spots in their lungs.

The report was made by Doctors Alvan L. Barach, Artell E. Johnson and Colter Rule, of the College of Physicians and Surgeons, Columbia University. The doctors making the experiments were not identified. Both since have recovered.

Their experiments were made in a steel chamber of a sort used by the army and navy to produce air conditions of extreme altitudes at which the latest fighting planes sometimes must fly.

The chokes, an affliction of extremely high altitude flying, were also described to the Association.

The chokes are coughing, something like asthma. Of themselves, they are not dangerous, but they endanger combat aviators, because a choking man cannot keep on his oxygen mask. He cannot live at high altitudes without his mask, so he must descend to lower altitudes, where flak is dangerous.

Doctors of Medicine as Others See Them.—"During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest."

The above item, with some quotations, appeared in CALIFORNIA AND WESTERN MEDICINE: July, 1942, issue, pp. 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, 1943, issue, pp. 49 and 50; February, pp. 92-93; April, pp. 255-257; May, pp. 305-308; July, p. 96; and August, pp. 146-147; September, 1943, p. 197. More recent items follow:

DOCTORS AND WAR

Experience will ever be foremost in importance in developing the efficiency of the individual and we may therefore look forward to the return of the thousands of medical men who are serving their country with the armed forces with a feeling that they have taken a postgraduate course which better fits them for service at home in times of peace.

In the past, when great battles were fought, loss of life was multiplied because of lack of prompt and adequate medical care for the wounded, the mentally sick and victims of the strange ailments developed in foreign lands. In the present war the story has been different. "Medics" have been given better preliminary training, better equipment and supplies. Now they are getting the experience of actual administration.

Even yet the full amount of the achievements of medicine on "D-Day" has not been fully impressed upon the country. It is reported that within forty-five minutes after the first troops landed on the shores of France, a medical unit was on the beachhead picking up the casualties, while in the background a landing craft was being converted into an operating theater.

Fifty thousand American doctors are in the armed forces and all are now trained experts at the business of saving lives. And while we think of the doctors and their trying experiences in both the battle areas and hospitals, we should not forget the doctors who have had to remain on the home front where all are working day and much of the night to care for the afflicted. They, too, are acquiring experience beyond which they would not have gone in peace times.—Chico *Record*, September 2.

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MODERN MIRACLE

The records established in production, in training and outfitting armies, and in meeting the thousands of other emergency needs of war, constitute modern miracles, unbelievable in any earlier era. But the greatest miracle of all is in the daily record of lives saved and maimed bodies reclaimed. There, America's military medical men have a record of achievement that is both magnificent and heart-warming.

A war department announcement reveals that our gallant medical corps men and women are bringing about the recovery of 96 per cent of all the men wounded in action—and that about two-thirds are returned to active duty.

Part of the credit for this miracle is given to modern mobile surgery which brings treatment to the men on the front lines. The dangerous delays of previous days when wounded men were brought to base hospitals in the rear before receiving treatment have been eliminated. New reconditioning techniques developed by the armed forces also have played a major part in achieving today's medical miracles. Every modern technical device and procedure are employed in restoring wounded men to health. Strange gadgets are used to strengthen limbs backs, and abdomens gone flabby. In competitive games the men forget the casts on their limbs.

The medical record of World War II, compared to that of World War I, is miraculous indeed! But the armed services are not satisfied with achieving a 96 per cent rate of recovery. Continual research is in progress to make the record even better. The miracle men of the medical corps are accomplishing wonders in softening war's tragedies, and all America owes them a great debt of gratitude.—San Mateo *Times and Leader*, September 7.

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Ask Your Own Doctor What He Thinks About This

Yesterday a Hanford doctor told the writer that one of these days the government is going to "force" him to retire from the practice of medicine.

He says that when the practice of medicine is socialized so that the government tells the patient what doctor to go to and when and where, he will feel compelled to stop being a doctor then and there.

We wondered about that. Today, your youngster is encouraged to attend high school, college and then perhaps medical school. He will serve many long years of apprenticeship both in school and in the first hard years after graduation. He will work many years for a very small income. But under the American system he still has the opportunity to become a great doctor or surgeon —to be better than the average, to be sought after for his talents.

If this is changed so that all doctors are lumped together like so many points in a ration book, your son may not aspire to become a medical student. Other people's sons may not want to suffer the long, tedious years of study and work required for good medical training. Then the brilliant medical history that has been written in these United States may begin to taper off. The progress we have made may be sharply curtailed, insofar as it benefits you and your family if you are forced to rely on a government doctor.

The arguments for and against socialized medicine are certainly confusing. Certainly some sound method of providing medical assistance for the needy and underprivileged can be maintained without destroying the fundamental principle of free enterprise which has developed so many great doctors, lawyers, surgeons, inventors, businessmen, etcetera in America.

Ask your own doctor what he thinks and what he knows about this. Our friend was deeply disturbed about the subject. It is vital to you and your family, as it is to every American. If you have an opinion, write a letter to the editor of this newspaper so that we can publish it and let others know what Hanford people think in regard to this subject.—Hanford *Journal*, August 26.

War Helped Here

The medical department of the Army has declared unequivocally that atabrine, the war developed substitute for the treatment of malaria, is even more effective for this purpose than time honored quinine.

Particularly important is the statement that atabrine has a high percentage of cures in the treatment of falciparum malaria, against which quinine has been of doubtful value.

Though the emoluments from war are few as compared with the terrific cost, they are not entirely nonexistent. Atabrine is but one of many which could be mentioned.

War demands what it needs, and in the development of those things serves in effect as a catalytic agent. Fortunately many of these discoveries can be used in peacetime for the benefit of mankind.

But how much better off the world would be if the same amount of energy, inventiveness and skill were employed solely for the advancement of the human race without paying the terrible price of war.—Fresno *Bee*.

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Keep the Horse before the Cart

Recently a business man accosted a friend who said: "Well, Doctor, I see where they are going to socialize your business under the Federal Social Security Act."

The Doctor, who had spent his life helping the ill and afflicted in his community, regardless of their financial circumstances, said: "Oh no, my friend, they are going to socialize you. When the Federal Government takes six per cent from your employer on wages paid up to a specified amount, tells you what doctor to go to, when, and where, you will be getting the benefits of socialism, not I. When that day comes I will go back to pipe fitting, which is just working with a different kind of pipes than those in a human."

Yes, it's the public, not the doctors, that would suffer from politically appointed physicians. There would no longer be incentive for the better doctors to carry on. An independent pipe fitter would have more future than a socialized doctor.—San Francisco *Noe Valley Progress*, August 24.

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Let Them Speak

More than 55,000 doctors are serving in the armed forces. A few years ago they were busy carrying on medical practices and bettering the health of the communities in which they lived. War removed them to faraway corners of the world. But they still find time to consider vital questions affecting the medical profession. A medical officer recently addressed a plea to every physician and medical organization on the home front. He said: "Please help keep the practice of medicine out of government control."

Commenting on this mute appeal, Medical Economics says: "Every medical society in the country should have a committee to help preserve free medicine. Such committee should tell the doctor in service about the problems they're up against and how they're attempting to counter them. Let them assure him that if it is humanly possible to do so his civilian colleagues will keep political opportunism out of medicine.

"More than anything else, the men who are fighting for us want a chance after the war to pick up where they left off. The least we at home can do is to try to assure them that chance. Legislation of the Wagner variety (to socialize the medical profession) must not be permitted to pass at a time when so many of our profession are absent from the country on active duty. They're entitled to express themselves at least on a proposal that would, if adopted revolutionize the practice of their profession. . ."—Vallejo *Times Herald*, August 12.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Governor Dewey for Broader Health Provisions

Tonight I am going to talk about another aspect of this great question:

How we are to obtain greater security for the men and women of this country in their personal lives and what the United States Government should do about it. . . .

Fourth: We must help to develop a means for assurance of medical service to those of our citizens who need it, and who cannot otherwise obtain it.

This is a task that must be carried out in coöperation with our medical men. There can be no group better able to advise on medical care than the medical profession. Yet, unhappily, this is the very group which the New Deal has managed to alienate. Our free and independent medical profession has advanced medical science in America ahead of every other nation in the world. Its freedom has made it great. It should be encouraged, not discouraged.

Let us enlist the leadership and aid of the doctors of America in organizing our private and public hospitals as well as our other services into a fully effective system to protect the health of all our people.—San Francisco *Examiner*, September 23, 1944. (Editorial comment on p. 183.)

Sale of Government Surplus Medical Supplies

A big fight in the Senate-House conference committee on surplus property disposal came on the proposal that surplus educational and health supplies be given to schools and hospitals. Senator Lester Hill of Alabama and Representative Bender of Ohio led the fight for this proposal, with Mississippi cotton-grower Whittington leading the three-man opposition.

Shortage of surgical equipment and other hospital needs is well known, and educational authorities are extremely worried about replacing school equipment. The schools have trained over nine million people of all ages for war jobs in the past few years, and their equipment has depreciated alarmingly. New equipment is not available and, even if it were, few schools have the funds to buy it.

After a full two days of argument, and just as the committee was ready for a third time to give up, Missouri's level-headed Jack Cochran finally proposed a substitute which was soon agreed upon. Alabama's Manasco and Mississippi's Whittington were not satisfied, but they were now a minority of the House delegation and so had no choice but to accept.

The Cochran compromise permits the Federal Government to sell equipment on special terms to hospitals and schools, or to lease it to these institutions.—Drew Pearson in "Washington Merry-Go-Round," San Francisco *Chronicle*, September 18, 1944.

Cradle-to-Grave Security Plan Submitted to Britain

London, Sept. 25.—(AP.)—The British government prepared today to present a gigantic all-embracing "prosperity and happiness" plan for national social security—at last providing its answer to the ambitious but controversial Beveridge plan of a year ago.

The plan, calculated to cost $2,600,000,000 the first year compared with $2,788,000,000 for the Beveridge plan, will be offered in the House of Commons in the form of a white paper as the House meets tomorrow after a seven-week vacation.

The plan would affect every man, woman and child in Britain, and cover human needs from the cradle to the grave as does the Beveridge plan.

It would provide unemployment and sickness insurance, health service, widows pensions, retirement pensions, family allowances, orphans allowances, motherhood grants, and its proponents will claim it is the greatest social security charter ever introduced by any government in any country.

The government doesn't propose to put it in operation until after the war.—San Francisco *Chronicle*, September 26.

Richmond Bay Area Doctor Shortage

To discuss a means of increasing medical care for residents and workers of Richmond, a group including the mayor, city health representatives, members of the county medical society, the War Manpower commission and civic groups attended a closed meeting of the Labor Health Council, which was held on August 24, at 601 Nevin Avenue.

The meeting was called by the city council at the request of the Bay Area Joint Labor Health Council of the AFL-CIO, which pointed out that the shortage of physicians and trained medical personnel in this area was dangerous to the health of war workers and other citizens.

In the letter requesting the meeting which was sent to the city council, Joint Labor Health Council officials emphasized the effect which the medical shortage is having upon absenteeism of war workers.—Richmond *Independent*, August 24.

Dr. Karl L. Schaupp Is Willing to Learn—and Wants to

And Maybe That's Why Mayor Lapham Picked Him For Job

Just after Karl L. Schaupp, M. D., was sworn in as the newest member of the Board of Education in Mayor Lapham's office Saturday afternoon, he turned to Bob Letts, the mayor's executive secretary, and said:

"When does the board meet? And where?"

The question typifies Dr. Schaupp's attitude toward his new job. He doesn't know anything about it, and freely admits it. It is more than possible this influenced the mayor in picking him, because there were plenty of candidates in San Francisco who knew all about it. . . .

He is by profession an obstetrician. He is also a teacher, having taught obstetrics to a dozen academic generations of Stanford Medical School students.

But, he is quick to point out, this doesn't give him any professional standing as an educator. "There's a vast difference between graduate students, to whom knowledge of their subject is money and prestige, and youngsters, learning the fundamentals more or less involuntarily," he said. "It's obvious the two problems are entirely different."

Agrees on Hill Report

He is in agreement with the core of the Hill report—that the function of the Board of Education is to lay down broad policies, and not to administer the school system.

"The board has already approved that principle," he said. "There's no longer any controversy over it—if there ever was," he added, diplomatically. . . .

His medical training and practice has given him two points of view, he thinks, that may influence his work on the board. One is the habit of thinking in terms of people—in this case of children. "I'm not interested in statistics. Personal problems, personal adjustments, personal happiness are what interest me," he said.

The other is not to make up his mind—not to diagnose—until all the facts are in. "I have no idea of what changes of policy may be needed for the school system here—maybe none. But Mayor Lapham asked me to serve, saying some improvement was necessary. I'm entering upon the job without any preconceived ideas. I'll do the best I can." . . .—San Francisco *News*, September 18.

My Day

By Eleanor Roosevelt

Hyde Park, Sept. 19.—I happened to see the other day that Dr. Martha Eliot, assistant chief of the Children's Bureau [E.M.I.C. supervisor], is urging more women to become doctors. It was a long fight before women were finally accepted into the Medical Corps of the Armed Forces, but they are now in. Here at home, the shortage of doctors has given women a chance to practice in a broader field than they would have had an opportunity to enter before. The war quotas which formerly held down the number of women admitted to medical schools have been eliminated, and the whole outlook for women in medicine is more favorable.

One particular phase of medical care, I think, will be benefited above all others if the number of women doctors is increased. In rural communities it has always been difficult to obtain good doctors. If scholarships could be given to women, with the understanding that they would then serve a few years in rural areas, I think we could greatly improve the standards of health throughout this section of our population.—E. R.—San Francisco *News*, September 20.

"Our Feet Are Taking a Beating"

Chicago, Sept. 14.—Women take off their shoes at the movies and men kick off their shoes for slippers on coming home because "our pedal extremities are taking a beating," according to Dr. Lemuel C. McGee, of Wilmington, Del.—San Francisco *News*, September 14.

It takes dissatisfaction to get useful ideas going.—Donald A. Laird.

LETTERS†

Concerning Social Security Representatives That Physicians Must Register If They Give Emergency Professional Services for Colleagues:

(COPY)

September 25, 1944.

Room 1331, 450 Sutter Street
San Francisco 8, California

Paul C. Barton, M.D.,
Executive Officer,
Procurement and Assignment Service,
Washington 25, D. C.

Dear Doctor Barton:

Recently a great deal of disturbance and interference with the practice of medicine in the case of several busy practitioners has been brought about by the agents of the United States Treasury Department, Bureau of Internal Revenue. This sounds pretty ominous, I know, but it is also serious, and to me, inexcusable.

A Miss Anne Dunn, whose chief I believe is Mr. Albert Sellinger of the Bureau of Internal Revenue, 100 McAllister Street, San Francisco, California, has recently been interviewing certain doctors, and I believe it is contemplated that they are going to canvass the whole field, with a view to determining whether these doctors are paying any other physician for taking care of his patients during his vacation, or during an emergency when he is unavailable through any reason whatsoever. These agents state that if a doctor compensates a confrere for visiting one of his patients in the middle of the night, or when he is on vacation, the doctor who makes the visit must register under Social Security, must pay a certain amount of money for this fee, and that the doctor for whom he has performed this service and who has reimbursed him must also pay a certain sum to Social Security. I have given you this simple case, which is an actual case, in order to show how far certain departments in the Government are reducing certain laws to absurdity. It means that at this time, of all times, when every physician is practically killing himself to take care of the civilian population, that for the sake of carrying out some theory to the 'nth degree, the physician is now being asked to go through a great deal of time-consuming work in order to satisfy some crackpot regulation which was never meant to cover these cases and is only cutting down and interfering with the medical care of the civilian population. The probable actual number of dollars and cents is so little as to be meaningless. Furthermore, practically every physician who makes an emergency call for another physician or takes care of certain patients for a physician who is sick or even on vacation to keep from being sick, has his own practice, is self-employed and does not wish to be registered under Social Security or take the necessary time and carry the necessary bookkeeping, and make out the forms necessary to carry on such an absurd program.

The above does not apply to physicians who are hiring assistant M.D.'s on a salary basis for full or part time work. Such cases very conceivably come under the intent of the Social Security regulations and there is no objection to this. The absurdity lies in carrying this to such an intolerable degree. I do not know whether this procedure here in San Francisco is based on a national direction or whether it is possibly the idea of some local sub-department head, but I believe that it is to the interest of the Procurement and Assignment Service and to the medical profession to determine this.

I do not know of any profession that is taking the beating because of the number of members in the military forces, that the medical profession is. It has become absolutely necessary for doctors to spell and relieve one another in order to, in any way, maintain their own health and efficiency during this emergency. Many of us are taking care of the practices of other physicians while they are in service, and reimbursing them for a percentage of the income received from their patients. This is a pure partnership basis. Similarly, many physicians are taking night calls or week-end calls on a rotational basis while their confreres are absent. Remuneration for this is also on a partnership basis in the individual case. If now, in addition to doing their utmost to cover this emergency situation, the Treasury Department is going to throw a lot of extra work on the medical profession in order to dot an *i* in an isolated sentence, to comply with someone's interpretation of an otherwise good law, we, in this country, are certainly in for a bad time.

It is my request and suggestion that the Central Board in Washington immediately investigate the source and authority and reasons for the above procedure on the part of the local, if not national, department of Internal Revenue, with a view to obtaining some means of relief for the medical profession. If persisted in, this is going to, and as a matter of fact is, interfering with the efforts of Procurement and Assignment Service and the efforts of the medical profession which is doing such a noble job during these trying times. Already I am having doctors call me up saying that they will not make any more calls for other physicians if they have to go through all this red tape, because they are performing an act which is helping out a physician, which they are in no way obligated to do. Although I have not been approached personally, I imagine that I will be in the near future. I can only say this, that several confreres have realized that I was giving my time to War Manpower at a terrific financial and physical sacrifice and they have gladly and patriotically released me of night calls during this emergency and during the absence of my brother who is in the Navy. In a great many cases I have reimbursed these physicians for covering me in these emergencies, paying them either all or part of the fee which I have collected from the patient who was glad to have this physician in my absence. If I have to now go back through my books for the last two years and ferret the exact sums of money which I have paid on individual cases, and have to fill out Social Security forms for these various physicians, and if these various physicians are forced to take out Social Security numbers and go through similar red tape of reporting these fees, I will certainly have to not only resign from Procurement and Assignment Service, so that I may work for Social Security, but I will also immediately give up any attempt to cover my patients through making available to them the services of other physicians.

I would appreciate your reactions and the reactions of the Central Board regarding the above, and I would also request that you investigate and inform me as to what the future holds regarding it.

With kindest regards, I remain,

Sincerely yours,
HAROLD A. FLETCHER, M.D.,
California State Chairman for Physicians Procurement and Assignment Service.

(Medical Jurisprudence. Concluded from p. 227)

Accident Commission approved a surcharge of 15 per cent over the existing fee schedule effective August 1, 1944. This order of the Industrial Accident Commission will be discussed more at length in the next issue.

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† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

MEDICAL JURISPRUDENCE†

Hartley F. Peart
San Francisco

California Workmen's Compensation Act As It Affects Physicians and Surgeons

This is the second of a series of articles commencing in the September, 1944, issue of California and Western Medicine (page 177), with reference to the above subject and with particular emphasis being placed upon the fees of physicians and surgeons in industrial injury cases.

In October of 1942, by direction of the Council of the California Medical Association, there was filed with the Industrial Accident Commission an application for the adoption of a new, complete and adequate medical and surgical fee schedule to serve as a guide for the Commission in making awards in industrial accident cases and to supplant the existing inadequate and outmoded schedule originally adopted in 1913 and readopted with but a small increase in 1920. The fee schedule in current use lists only 87 procedures and operations while the proposed new schedule presented by the California Medical Association lists 543 medical and surgical procedures and operations, which experience has shown are encountered in industrial cases. In its new fee schedule, the Association sought to revise the compensation fixed for the 87 items set out in the old schedule and to establish for the first time reasonable compensation for 450 new items.

On February 15, 1943, the Industrial Accident Commission held a public hearing upon the proposed schedule at which the C.M.A., private insurance companies, the State Compensation Fund and self-insurers were represented. Upon completion of the hearing, the new schedule was taken under advisement. After giving the matter its consideration, the Commission raised as a major objection to the adoption of the new schedule the fact that in its opinion the Commission would not have the necessary authority to enforce compliance with the schedule by employers, private insurance companies and physicians throughout the State. Mr. Paul Scharrenberg, Chairman of the Commission, cited Section 5304 of the *California Labor Code* as the primary obstacle to adequate control by the Commission of fees paid to physicians in industrial injury cases. This section reads as follows:

> "The Commission has jurisdiction over any controversy relating to or arising out of sections 4600-05 inclusive (Sections relating to medical care) *unless an express agreement fixing the amounts to be paid for medical, surgical or hospital treatment as such treatment is described in those sections has been made by the persons or institutions rendering such treatment and the employer or insurer.*" (Italics supplied.)

The legal effect of this section is to take away from the Commission jurisdiction to determine medical fees, in any case, where there has been an express agreement made between the physician and the employer or insurance company covering fees to be paid. The Industrial Accident Commission cited instances where physicians agreed to make rebates to the insurance companies with the Commission having no power to prohibit such a practice. It was suggested by the Commission that this would have a detrimental effect on the State Compensation Insurance Fund because, whereas the state operated company would comply with the proposed fee schedule if it should be adopted, the private companies would be free to force rebates from physicians and thus achieve an advantage.

It was the opinion of the Council of the California Medical Association, that in spite of *Labor Code*, Section 5304, most private insurance carriers would abide by the new schedule and that the Association could control agreements between physicians and insurance companies by disciplinary action against any member of the Association who might enter into an agreement with an insurance company to accept fees less than those set in the new fee schedule or to rebate on established fees. Notwithstanding its opinion in this regard, the C.M.A. wished to meet the objection raised by the Industrial Accident Commission and to this end procured the amendment of Assembly Bill 292, and the introduction at the 1943 session of the California Legislature of Senate Bill 1097. These bills proposed to add a new section to the *Labor Code* which would, in effect, prevent agreements between physicians, hospitals and workmen's compensation insurance carriers which had for their purpose the payment by insurance companies and acceptance by physicians of compensation less than that prescribed in the new fee schedule, should it be approved and adopted by the Industrial Accident Commission. Sanctions were provided in the proposed amendment to the law which would make it readily enforceable against both physicians and insurance companies who might attempt to deviate from the established fee schedule. Unfortunately, the bill met with such determined opposition on the part of some insurance companies that efforts to bring about its passage were unavailing.

It is true that under the existing law the Industrial Accident Commission is not given jurisdiction over controversies involving the fees for medical services in industrial injury cases where there is a written contract establishing the fee between the employer or his insurance company and the physician. Amendments to the law along the lines of Senate Bill 1097 are extremely desirable, but notwithstanding this defect in the law, urged as the bar to adoption of the proposed new fee schedule by the Industrial Accident Commission, the C.M.A. felt a revision of the schedule was none the less imperative. Accordingly, the C.M.A. diligently pursued its efforts to bring about approval of the new fee schedule. Some measure of success was achieved by the Association when, on July 18, of this year, the Industrial

(Concluded on Page 226)

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVII, No. 10, October, 1919

EXCERPTS FROM EDITORIAL NOTES

Are There Enough Doctors?—Common opinion, both lay and professional, says that there are enough and more than enough doctors to supply the medical needs of the country. Recent circumstances, however, throw considerable doubt on the accuracy of this conclusion. The difficulty of the Army and our allies in obtaining the doctors needed for the war was a surprise. Also were we surprised to find the dearth of physicians in many localities when the military need had been met. Hospitals, clinics and laboratories were confronted with a serious problem in the scarcity of doctors. Industrial concerns and public health agencies likewise reflected the lack. The difficulty in filling the military needs was followed by the drafting of senior medical students even, and then the experience of England and the startling shortage of doctors in civilian lines led to a careful conservation of the available supply of doctors and the exemption of medical students. Even under these extreme conditions, the statesmanlike attitude was preserved that only high class, well-trained doctors are wanted, and the multiplication of medical schools was discouraged and inferior schools were closed.

Dr. I. M. Rubinow in a recent issue of the *Medical Review of Reviews* undertakes to analyze the question of the supply of doctors in proportion to the demand for them. He estimates the total number of doctors in the United States at 150,000 roughly, as compared with 133,000 lawyers, 134 000 clergymen, 140,000 music teachers and 600,000 teachers of all sorts. It is unnecessary here to dispute over the relative importance of these various classes. Certainly, however, the average family has greater need for a doctor than a lawyer and certainly a doctor cannot expect to serve as large a clientele successfully as can a clergyman. An estimation of one doctor per 600 or 700 population means nothing because of diverse conditions in different sections. . . .

Editorial Comment.—Why do all the new medical graduates wish to locate in a city? Why is there a greater shortage of doctors in small towns and the country than in the cities?

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Need for a State Hospital School for Indigent Crippled and Deformed Children," by Harry Leslie Langnecker, M.D., San Francisco.—Most physicians and many laymen, realize the necessity for better treatment and care of indigent crippled and deformed children. Those members of the medical profession who are intimately interested in the treatment of these correctable defects, understand better than anyone else, the lost opportunities in the neglected and untreated cases. Not until last year, has any definite means

(Continued in Back Advertising Section, on Page 30)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M.D.
Secretary-Treasurer

Board Proceedings

Results of the San Francisco written examination conducted by the Board of Medical Examiners have been released. The records show that 142 Physicians and Surgeons, five Chiropodists and two Drugless Practitioners passed said examination.

At the recent written examination in Los Angeles, 126 applicants presented themselves for written examination.

Legal hearings were held on charges of infractions of various sections of the Business and Professions Code. The results of such hearings at the August meeting were as follows:

Anderson, Pearl J., M.D. License restored to good standing, 8/22/44.

Traxler, Paul S., M.D. License restored to good standing, 8/21/44.

Aronchik, Bernard, M.D. License revoked, 8/24/44.

Esker, George C., Jr., M.D., placed on probation for 5 years, from 8/23/44.

Froyd, Melvin Frankford, M.D., placed on probation for 5 years, from 8/22/44.

Gregg, Wendell Oliver, M.D., probationary period extended for 3 years, from 2/27/45.

News

"The State District Court has upheld a Superior Court verdict ordering restoration by the State Board of Medical Examiners of the license of Dr. Thomas D. Wyatt, Redding physician. Dr. Wyatt's license was revoked by the Board when it charged him with performing two illegal operations at a Redding hospital in March, 1942. The women involved testified in Superior Court that the operations were legal." (Anderson *News*, August 10, 1944.)

"Superior Judge Dal M. Lemmon today denied a defense motion for a new trial and sentenced Dr. M. A. Thompson, 45, North Sacramento chiropractor, to serve from two to five years in San Quentin Prison on abortion charges. Dr. Thompson was convicted by a jury a week ago on two counts of abortion involving a 17-year-old Sacramento girl. Each count of abortion is punishable by two-to-five-year terms, but the court directed in this case the two sentences shall run concurrently. Immediately following the passing of sentence, R. C. Fleming, defense attorney, filed a written notice of appeal to the District Court of Appeal . . ." (Sacramento *Bee*, August 28, 1944.)

"Mrs. Mattie Perkett, 45, of Farmersville, is in the Tulare County Jail here today following her arrest by Joseph Williams, investigator for the State Board of Medical Examiners, on a charge of violating the State Medical Practice Act by attending scores of mothers in childbirth in the Farmersville and Exeter districts during the last two years without having a license. Mrs. Perkett was employed as a cannery worker in Visalia,

(Continued in Back Advertising Section, on Page 52)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.
Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco 8.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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BOOK REVIEWS

(Continued from Front Advertising Section, Page 26)

Medical Corps. Foreword by Prof. Harvey Sutton, O.B E., M.D., F.R.A.C.P., B.Sc., D.P.H., F.R.San.I. Cloth. Price, $2.50. Pp. 91. New York: Philosophical Library, 1944.

The problem of malaria, its prevention and its treatment, is the outstanding problem of tropical life. It is estimated that at least five million human beings die from this disease every year. The loss of time in invalidity must be enormous. To the newcomer from areas free from the disease it may be a life or death struggle. Economic disaster awaits neglect of preventive measures in large undertakings.

Admitted that many of the questions that arise are controversial, Gunther's (the author's) first hand experience must be listened to with appreciation.

TWENTY-FIVE YEARS AGO

(Continued from Text Page, 228)

been taken to ascertain approximately how many children in this State, might be classed under the handicapped group. A survey of cripples under the age of eighteen, was successfully made by the California Federation of Women's Clubs, and a brief review of this report is worthy of comment. Although the desired information had to be gathered from a variety of sources, still, the investigation of 2148 authentic cases demonstrates the imperative need for action. . . .

From an Article on "The Surprising Frequency of Hypertension in a Group of Young Drafted Men," by Walter C. Alvarez, M.D., San Francisco.—During the

(Continued on Page 32)

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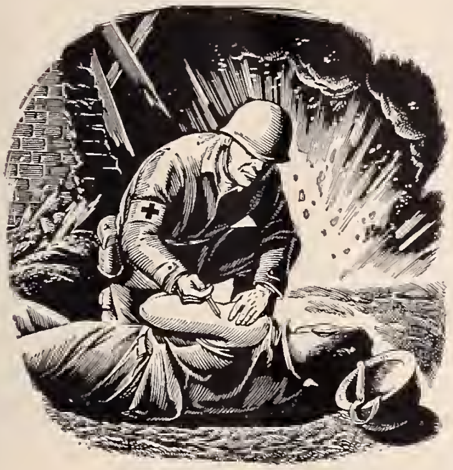

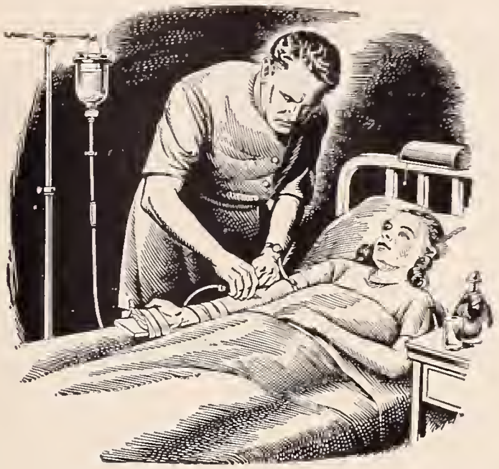

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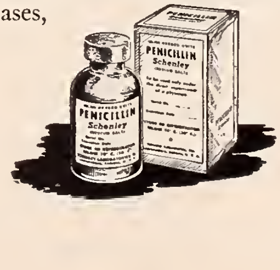

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The DAILY LOG

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

last few weeks of draft board work I measured the blood pressures of 264 recruits taken consecutively as they appeared for examination. There were 87 between the ages of 18 and 21, and 167 between 32 and 37. There were a few between 22 and 31. Although the number of cases studied is small, the results are so startling that it seems worth while to report them, if only to raise questions and to stimulate others to make similar studies on larger groups of young people. . . .

From an Article on "A Study of One Hundred and Fifty Cases of Hypertension," by Roland Cummings, M.D., Los Angeles.—The subject is so extensive that

(Continued on Page 34)

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TWENTY-FIVE YEARS AGO

(Continued from Page 32)

we have limited our studies to the etiology and the treatment as carried out in the cases reported. It seems best here to define some of the terms of expressions which will be used throughout the paper.

Apical abscesses are spoken of only when the x-rays have unquestionably demonstrated an abscess at the apex of the root of one or more teeth. The expression "bad teeth" refers to teeth that are crowned, or to a condition, which, from the appearance of both teeth and gums, is suggestive of root abscesses, but in which no x-rays were taken. . . .

From an Article on "Paralysis of the Esophagus," by H. Y. McNaught, M.D., San Francisco.—Paralysis of the esophagus is a comparatively rare condition. In effect it is a stenosis, as the esophagus acts solely by segmentary stimulation. Gravity plays no part in the passage of a bolus to the stomach. This is shown in the ability of the individual to swallow quite as well when inverted. When, however, a motor paralysis exists, no solids or liquids can pass to the stomach. Paralysis of other muscles of deglutition, such as the inferior constrictor and the palatal muscles, is frequently associated with esophageal paralysis. . . .

From an Article on "The Intensive Treatment of Meningococcic Meningitis," by Donald J. Frick, M.D., Los Angeles.—It is a peculiar fact that in medicine as in life generally, we only learn by hard knocks. We do

(Continued on Page 36)

FOR MEN IN COMBAT

when the going gets tough

To save the lives of men in combat through sustaining their mental efficiency by overcoming the symptoms of fatigue, BENZEDRINE SULFATE TABLETS are available for issue in the Armed Forces.

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Bush and Hyde Streets ***Telephone*** **PROSPECT 4321** **San Francisco**

TWENTY-FIVE YEARS AGO

(Continued from Page 34)

not seem to be able to apply quickly the lessons learned in the treatment of one disease to other diseases which are produced in a similar way, but have dissimilar manifestations. We have been impressed for a number of years by the advisability and necessity of intensive treatment in diphtheria, we have seen numbers of cases of tetanus recover following the employment of the "Rational" method of Ashurst and John, pneumonia Type I has been treated with large amounts of the specific serum with wonderful results, but not until we were placed face to face with the virulent epidemic of meningitis of last winter did we use our knowledge gained in these other diseases and evolve a satisfactory plan of intensive treatment. Report of the Surgeon-General, U. S. Army, 1918, shows there were 600 cases with mortality of 26.83 per cent for the last four months of 1917. . . .

From an Article on "Empyema—Treated by Dakin's Solution," by Guy Cochran, M.D., Los Angeles.—I have nothing either brilliant or new to add to the many empyema studies recently made. The severity of the disease has differed throughout the many scattered cities, camps and hospitals almost as much as the type of treatments and techniques. So reports and conclusions are just as varied. However, it seems worth while that reports should come from everywhere in order that out of the composite something may be learned. . . .

(Continued on Page 38)

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Mother has the satisfaction of knowing that making 'Dexin' formulas for her baby helps to assure sound habits of eating, sleeping and elimination.

The baby regularly takes his full quota of palatable 'Dexin' feedings. They are not excessively sweet, and do not dull the appetite. Adding bland foods to the diet is more easily accomplished.

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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

From an Article on "The Pathogenesis of Pachymeningitis Due to Nasal Operations, with Report of Cases," by Andrew B. Wessels, M.D., San Diego.—That there are relatively infrequent deaths following intranasal operations is shown by a review of the literature. Considering the number of nasal operations done, one wonders why meningitis as a complication is so seldom reported by the surgeon. In reporting my own case and putting on record three other cases operated on by other surgeons, but which have not been reported, I do so with the idea of getting closer to the pathology of the ethmoid labyrinth. . . .

Excerpt from State Society.—Acting upon the decision of the Council, the Medical Society has taken up the matter of acquiring new members. A great many good men come into our community who do not affiliate themselves with the county societies. Very often it is purely a matter of oversight. At other times there are men who have severed their connection with the county society for personal reasons, and do not reëstablish that relationship because they have not been asked. Therefore, we are undertaking a campaign and county secretaries may be called upon to coöperate with the Council in this matter. Our agent at present is Mrs. R. V. S. Berry who has been given full authority to canvass the state for new members and who is now at work on this rather comprehensive job. In the course of time she will visit practically every large center in California, and we shall expect the local county societies to give her all the assistance possible.

The Publicity Bureau has also established the beginnings of a lecture bureau, to be utilized by the county societies throughout the state. We have obtained a list of men of prominence in the profession who have agreed to go where they are called and deliver scientific talks, illustrated by lantern slides, when necessary, and specimens, and who represent the best thought in the profession today. . . .

(Continued on Page 40)

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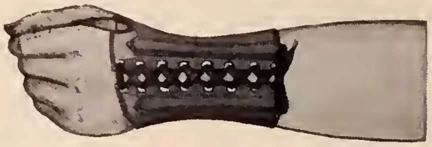

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TWENTY-FIVE YEARS AGO

(Continued from Page 38)

From an Article on "The Treatment of Gonorrhea and Syphilis in Women," by William E. Stevens and Maurice Heppner, San Francisco.—In a recent appeal addressed to the physicians of the country for coöperation in the fight against venereal diseases, the Surgeon-General of the United States Public Health Service states that there is danger of an alarming spread of these infections during the reconstruction period. He calls attention to the fact that many physicians are careless in their methods of treatment, and consequently responsible in a measure for the continued existence and dissemination of these conditions. This criticism applies with particular force to the conduct of these cases in women for, notwithstanding the very disastrous and at times fatal consequences of Neisserian infection in this sex, as well as the greater danger to the public at large, there is probably no other pathological condition of the female genito-urinary tract which is more often neglected. . . .

From an Article on "Perforation in Gastric and Duodenal Ulcers. Case Reports," by J. H. O'Connor, M.D., San Francisco.—In a series of 26,000 admissions to the Southern Pacific General Hospital, eight cases of perforating ulcers of the stomach and duodenum were encountered. In no case was the diagnosis made before admission. This is my reason for going rather minutely into the symptoms which lead to a correct diagnosis in these cases. . . .

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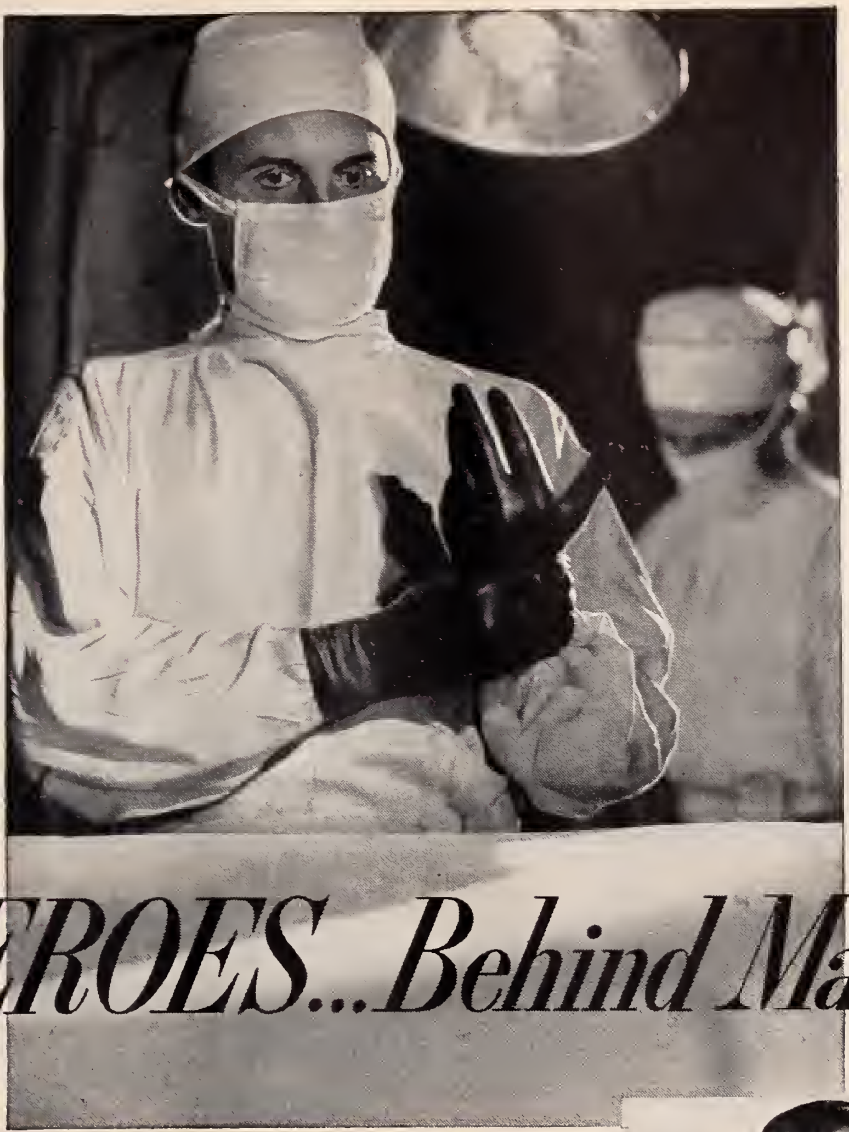

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✱ Reprint available on cigarette research —Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

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Literature on Request

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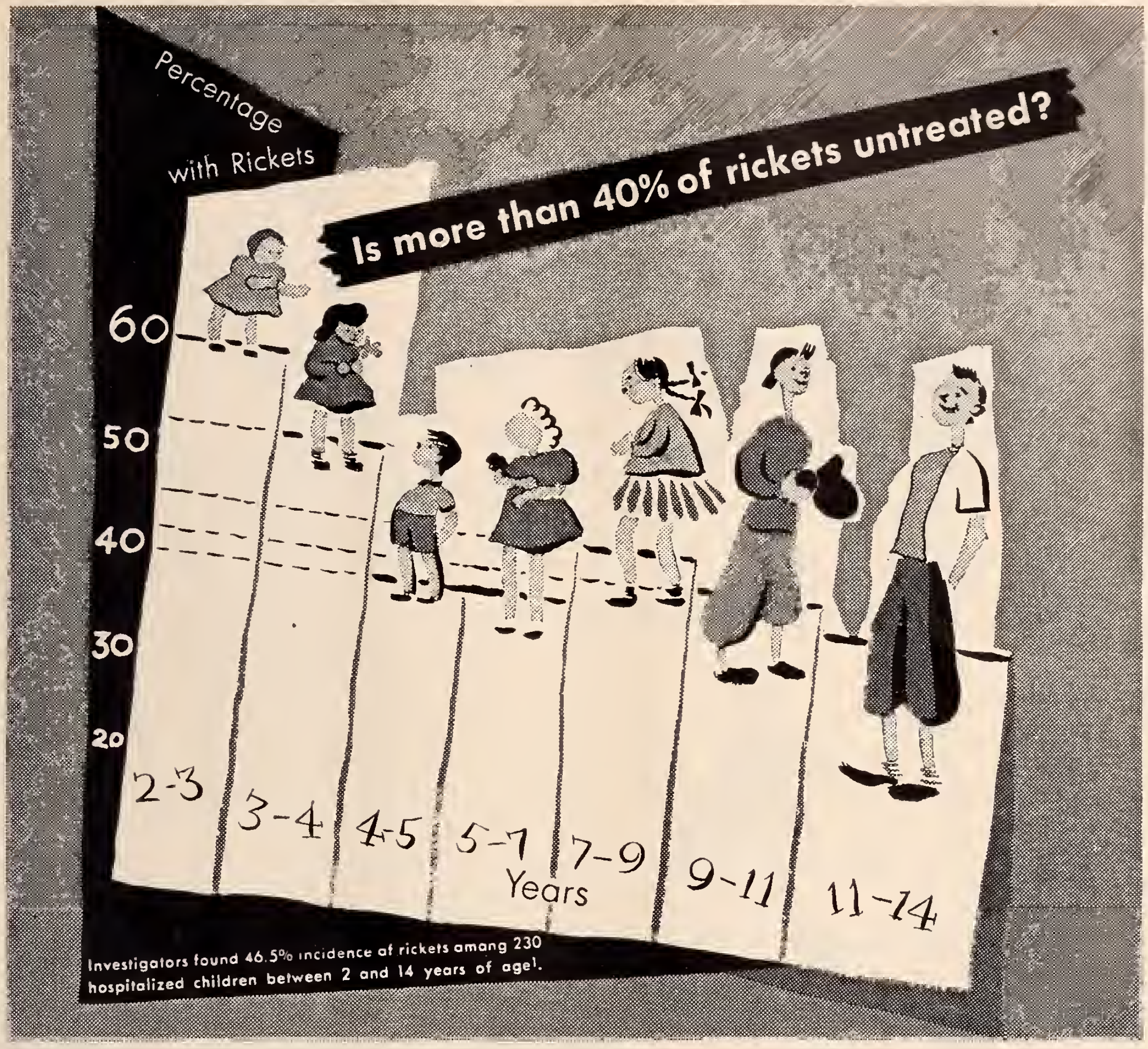

Investigators found 46.5% incidence of rickets among 230 hospitalized children between 2 and 14 years of age[1].

It used to be thought that rickets is prevalent only in the first two years of life. This was when the roentgenological and clinical manifestations were accepted as the criteria for diagnosis. Recent studies suggest that perhaps as the result of this impression, as much as 40% of rickets has gone untreated.[1]

Microscopic examination of the long bones of children between the ages of 2 and 14 who died from various causes showed a startlingly high percentage of cases of rickets in older children. The highest incidence was found during the third year (57%). This suggests the need of continuing vitamin D supplementation beyond infancy. Evidently, as long as growth persists, and at least through the fourteenth year, administration of vitamin D should be made routine; because even in children who *appear* healthy, histologic bone studies show that disturbances in calcium-phosphate metabolism are fairly common.

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1. Follis, R. H.; Jackson, D.; Eliot, M. M., and Park, E. A.: Am. Jrl. Dis. Child. 66:1 (July) 1943. Note: A reprint of this paper is being mailed to all physicians. Additional copies are available upon request.

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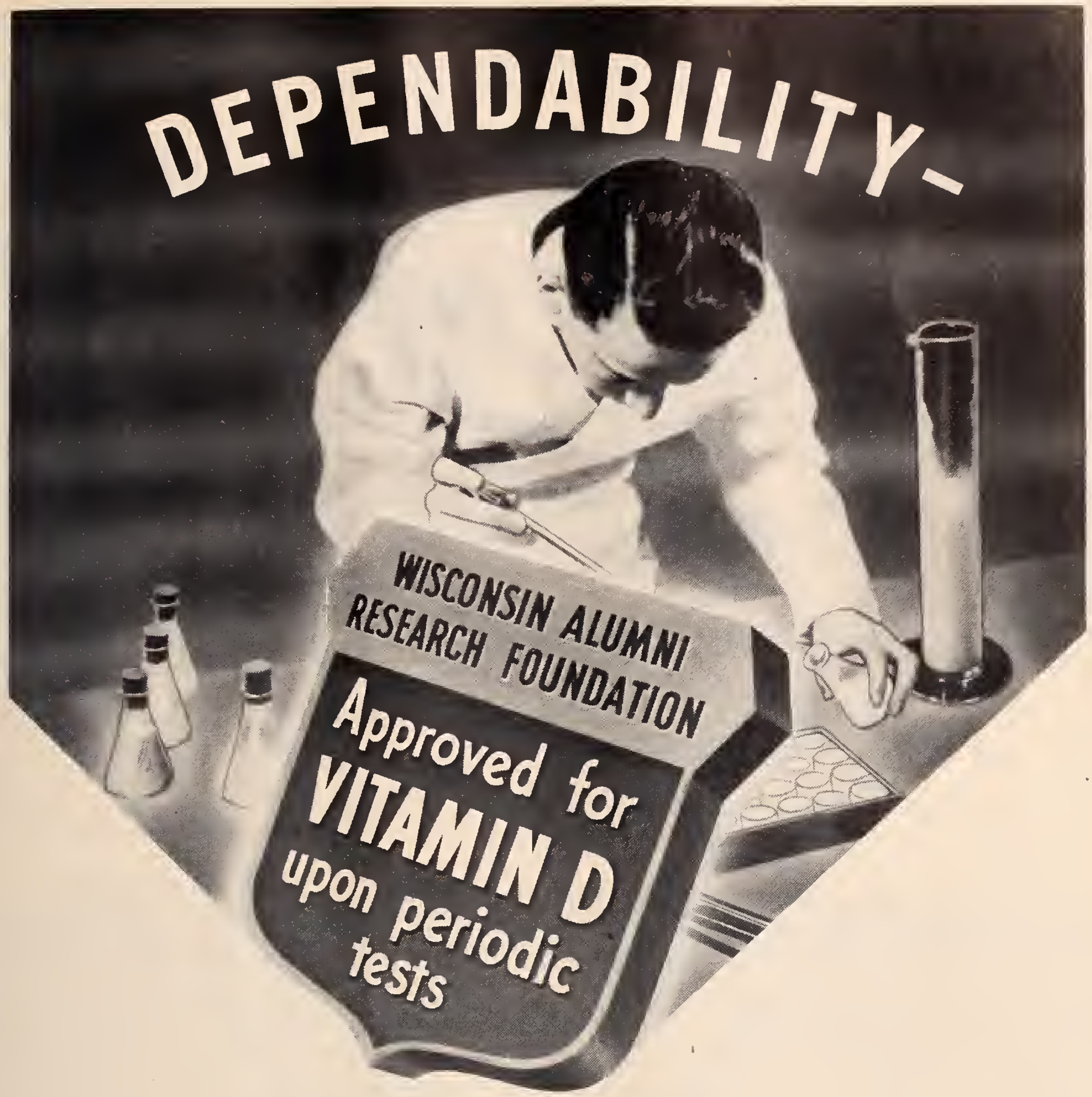
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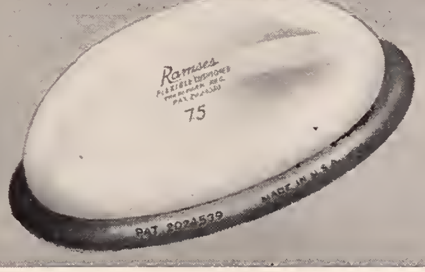

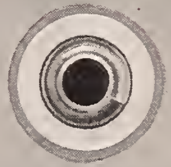

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page, 228)

and it was in this city that the arrest was made by Williams and Deputy Sheriff Arthur Mullen . . . Williams said Mrs. Perkett charged from $20 to $30 a case, and $2.50 for each extra call. He said she possessed scanty and unsanitary equipment . . ." (Fresno *Bee*, September 5, 1944, from the Press Dispatch dated Visalia, September 5.)

"For causing the death of Mrs. Julia Zubillaga, 26-year-old mother of five children, to which he entered a plea of guilty on July 13, Dr. Roland K. Harris, a chiropractor, must serve from one to ten years in San Quentin. That was the sentence of Superior Court Judge Leslie E. Still, after denying an application for probation filed by the chiropractor this morning . . ." (Long Beach *Press-Telegram*, August 14, 1944.)

"Suit for $10,000 damages against E. L. Lichty, Lomita Park chiropractor, was filed in Superior Court today by Mabel Williams, who charged he failed to discover or treat a dislocated left shoulder joint when she went to him for treatment between January 13 and February 14, 1944. The injury was sustained on January 13, according to the plaintiff, who asserts she had to be hospitalized for a period of eleven and a half weeks. J. Francis Shirley, San Francisco, is her attorney." (San Mateo *Times and Leader*, August 26, 1944, from press dispatch dated Redwood City, August 26, 1944.)

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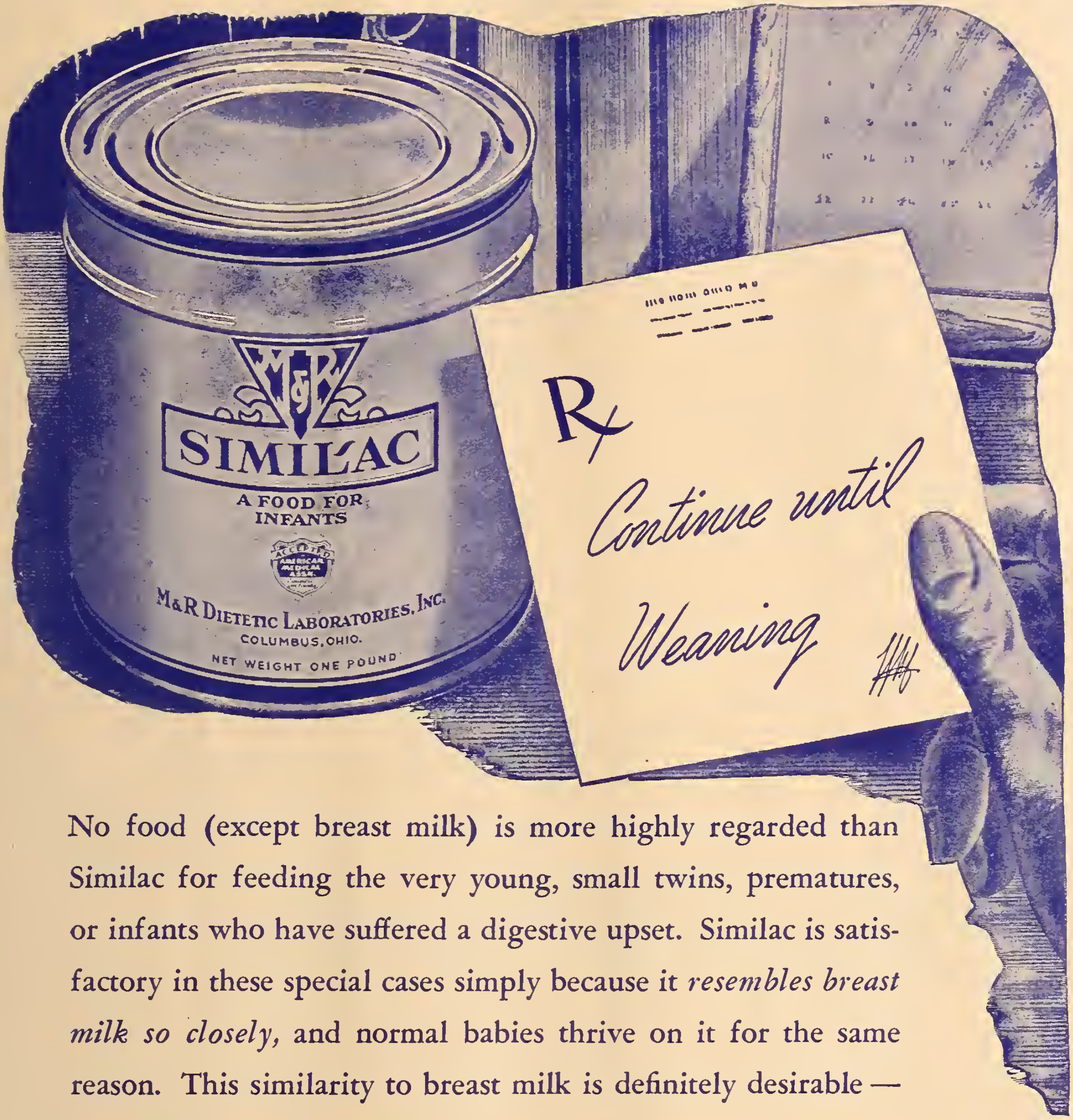
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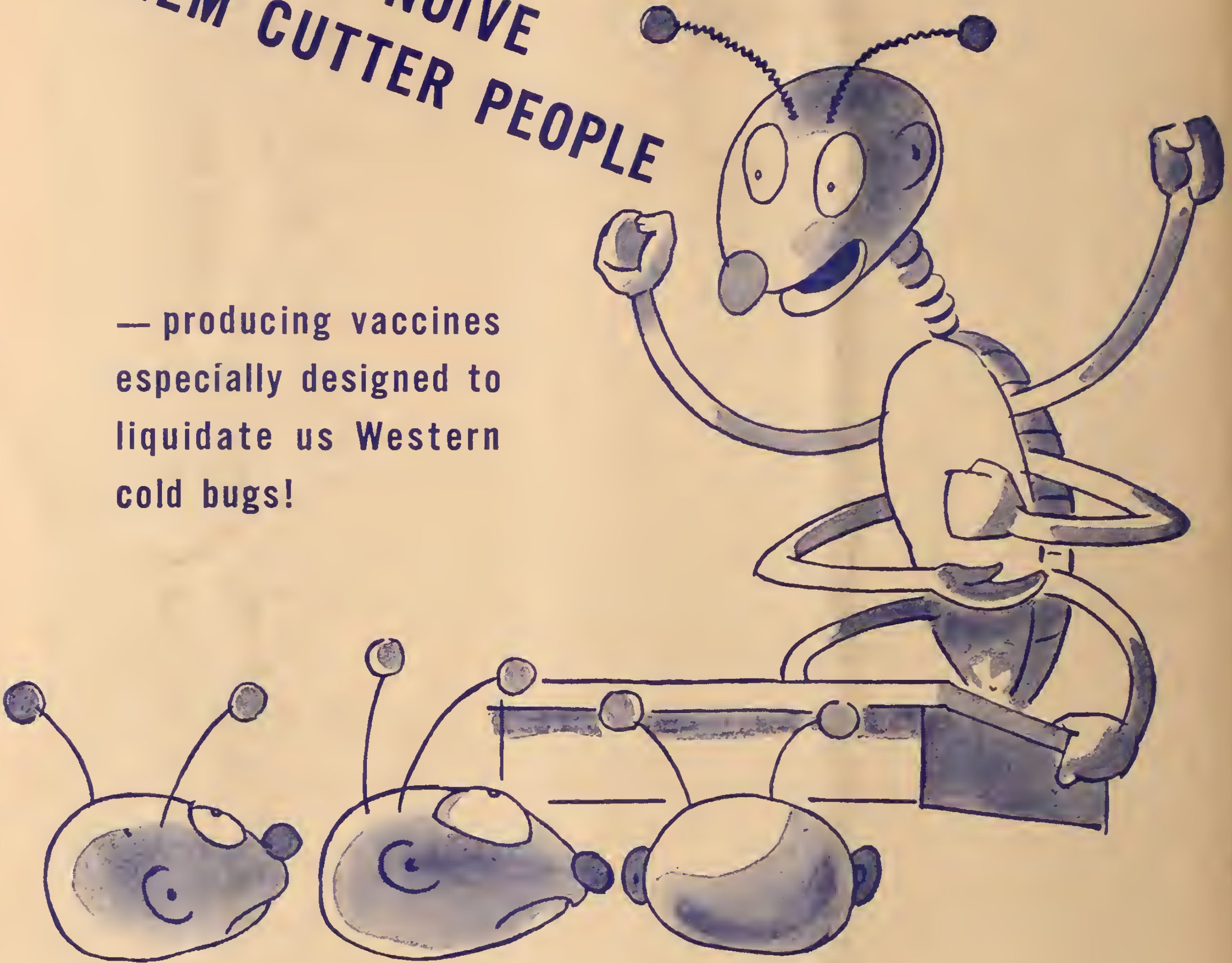

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1. Fauley, G. B., Freeman, S., Ivy, A. C., Atkinson, A. J. and Wigodsky, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med., 67:563-578 (Mar.) 1941.
2. Cornell, A., Hollander, F. and Winkelstein, A.: The Efficacy of the Drip Method in the Reduction of Gastric Acidity, Am. J. Digest. Dis., 9:332-338 (Oct.) 1942.
3. Winkelstein, A., Cornell, A. and Hollander, F.: Intragastric Drip Therapy for Peptic Ulcer; Summary of 10 Years' Experience, J.A.M.A., 120:743-745 (Nov. 7) 1942.
4. Upham, R., and Chaikin, N. W.: A Clinical Investigation of Aluminum Phosphate Gel, Rev. of Gastroenterol., 10:287-297 (Nov.-Dec.) 1943.
5. Lichstein, J., Simkins, S. and Bernstein, M.: Aluminum Phosphate Gel in the Treatment of Peptic Ulcer. Am. J. Digest. Dis. In Press.

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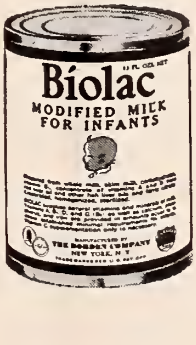

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Secretary, Gertrude Moore, 353 30th Street, Oakland, 9.
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Secretary, George C. Kelso, 416 East Fourth Street, Pittsburg.
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Secretary, Jerome A. Thormann, 2607 Fresno Street, Fresno, 1.
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Secretary, Marian Hubbell, El Centro.
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Secretary, Lloyd S. Bambauer, Bishop.
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Mendocino-Lake County Medical Society
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Orange County Medical Association
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Secretary, Russell I. Johnson, 181 Seventeenth Street, Westminster.
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Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton 3.
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George K. Dunklee, 1130 Garden Street, San Luis Obispo.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
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Secretary, Fred W. Borden, Sainte Claire Building, San Jose, 23.

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Meeting, *Sunday on Call.*

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President, H. Randall Madeley, P. O. Box 539, Vallejo.
Secretary, Charles H. Widenmann, 405 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo; Hotel Vallejo.*

Sonoma County Medical Society
President, William N. Makaroff, Guerneville.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Ralph E. Maxwell, 911 Thirteenth Street, Modesto.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, James C. Malcolm, 1501 West Main, Visalia.

Ventura County Medical Society
President, A. H. Stoll, 329 North Fifth Street, Oxnard.
Secretary, Gerald K. Ridge, 704 East Santa Clara Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, J. Homer Woolsey, Woodland Clinic, Woodland.
Secretary, Emery Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Joseph J. Salopek, 423 Fourth Street, Marysville.
Secretary, Harry Clemens, 725 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(For roster of C. M. A. committees and other organizations, see last month's issue)

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(Continued from Page 3)

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Hospital Service of Southern California, 743 South Grand View Street, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco 15. Phone WEst 8000.

Barlow Medical Library (Los Angeles County Medical Association), 634 So. Westlake, Los Angeles 5. Phone FItzroy 7694.

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". . . at least from 200 to 300 grams of protein is needed for replacement alone. One must give the patient as much food as he can take . . . give him a good protein, one that contains all of the essential amino acids." (Elman, R.: Physiologic Problems of Burns, J. Missouri M. A. 41:1 [Jan.] 1944.)

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BOOK REVIEWS

BOOKS RECEIVED

Encyclopedia of Child Guidance. Edited by Ralph B. Winn. Cloth. Pp. 456. New York: The Philosophical Library, 1943.

Virus Diseases in Man, Animal and Plant. By Gustav Seiffert. A survey and reports covering the major work done during the last decade. Cloth. Pp. 332. New York: Philosophical Library, 1944.

War Medicine: A Symposium. Editor Winfield Scott Pugh, M.D., Commander, (M.C.), U.S.N. Retired; Formerly Surgeon, City Hospital, New York; Associate Editor, Edward Podolsky, M.D.; Technical Editor, Dagobert D. Runes, Ph.D. Cloth. Pp. 565, illustrated. New York: Philosophical Library, 1942.

The Diagnosis and Treatment of Acute Medical Disorders. By Francis D. Murphy, M.D., F.A.C.P., Professor and Head of the Department of Medicine, Marquette University School of Medicine and Clinical Director of the Milwaukee County General Hospital and Emergency Unit, Milwaukee, Wisconsin. Cloth. Pp. 503. F. A. Davis Company, 1944.

Ventures in Science of a Country Surgeon. By Arthur E. Hertzler, M.D., Halstead, Kansas. Cloth. Pp. 304, illustrated. Privately printed by the Author.

Industrial Ophthalmology. By Hedwig S. Kuhn, Hammond, Indiana. Cloth. Price $6.50. Pp. 294 with 114 Text Illustlations, including 2 Color Plates. St. Louis: The C. V. Mosby Company, 1944.

(Continued on Page 10)

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BOOK REVIEWS

(Continued from Page 7)

A Hundred Years of Medicine. By C. D. Haagensen and Wyndham E. B. Lloyd. Cloth. Price, $3.75. Pp. 444. New York: Sheridan House, 1943.

The authors express the hope that their historical essay may prove to be of value not only to the layman, for whom it is primarily intended, but also to those medical practitioners and students who have not found time for any specialized study of the history of medicine.

The authors state that they have, therefore, presumed to select some of the important and more interesting aspects of the subject while omitting others which may be equally important but which are too technical to be readily described to the nonmedical reader.

The arrangement of this book has been determined largely by the fact that important medical advances are not made in a single day, but are generally the result of a laborious series of steps made by a number of different workers over long periods of years. Consequently the importance of each contribution to medicine can best be understood by tracing it separately from its origins rather than by attempting to survey the whole field of advance, in strict chronological order. Furthermore, they hold, by treating each subject separately it is possible for readers to appreciate the train of thought more clearly at a great saving of space and repetition.

The Romance of Medicine. The Story of the Evolution of Medicine from Occult Practices and Primitive Times. By Benjamin Lee Gordon, M.D., Member American Association of the History of Medicine; Attending Ophthalmologist to the Shore Memorial Hospital, Somers Point, New Jersey, and to Atlantic County Hospital for Tuberculosis, Northfield, N. J. Authorized Medical Examiner for Civil

(Continued on Page 12)

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BOOK REVIEWS

(Continued from Page 10)

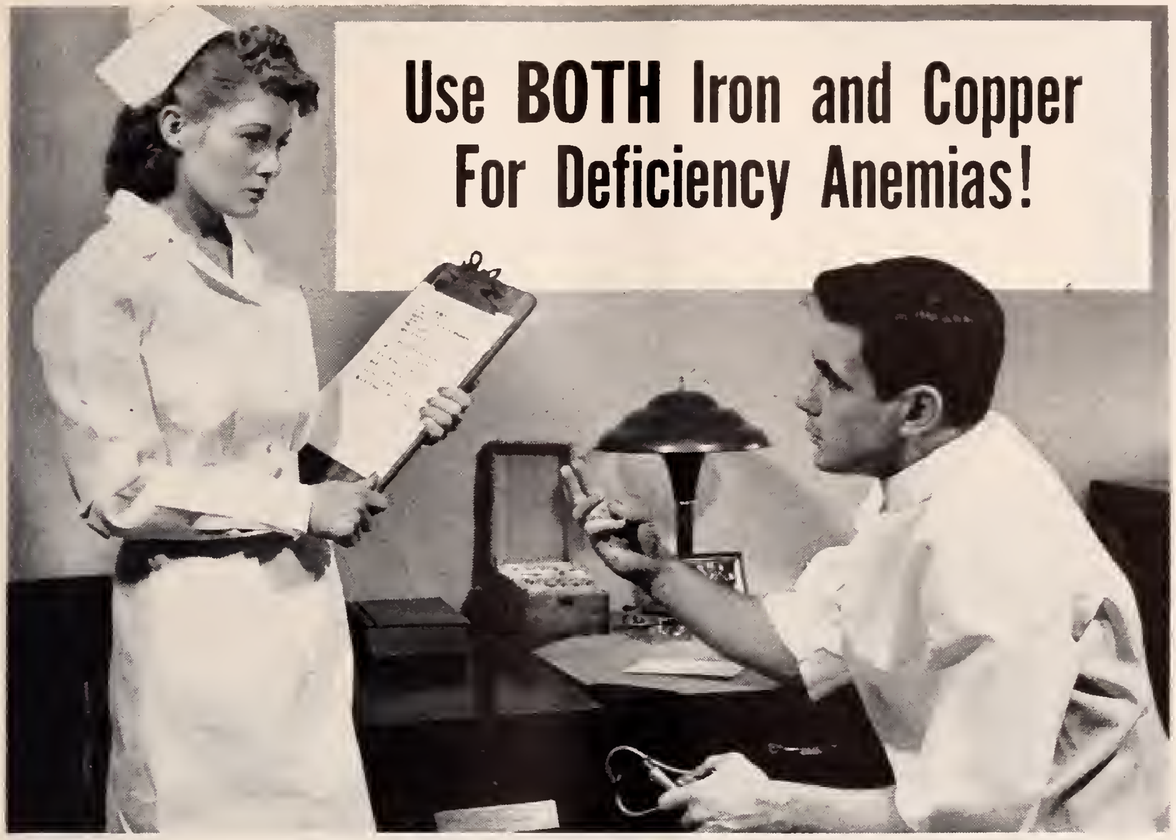
Aeronautics Administration, Dept. of Commerce, Washington, D. C. Formerly Associate Ophthalmic Surgeon of St. Agnes Hospital of Philadelphia. Cloth. Price, $5.00. Pp. 624. Philadelphia: F. A. Davis Company, Publishers, 1944.

In presenting his volume, the author stated he is not unmindful of the number of books dealing with medical history already available to the reader. He has, however, no knowledge of any work in the English language tracing so many modern medical and nonmedical facts, customs, and folklore to ancient medical concepts.

Modern medicine and modern customs are truly an evolutionary development of ancient animistic beliefs. The author states, if the right man did not appear at the right time, he could accomplish little. For example, Ehrlich, if he lived in the Hippocratic days, could not have discovered his "magic bullets."

Furthermore, few medical works classify and treat the development of medicine in accordance with the progress of the various basic branches. Primitive medicine, in most histories, is brushed aside in a few conglomerate pages, ignoring the basic fact that medicine had its birth with the first man, when he consciously or unconsciously recognized the blessings of health and life and strived to preserve them.

Certainly, there has been much of romance in the development of medicine. Gordon's work should be of interest, both to medical and lay readers



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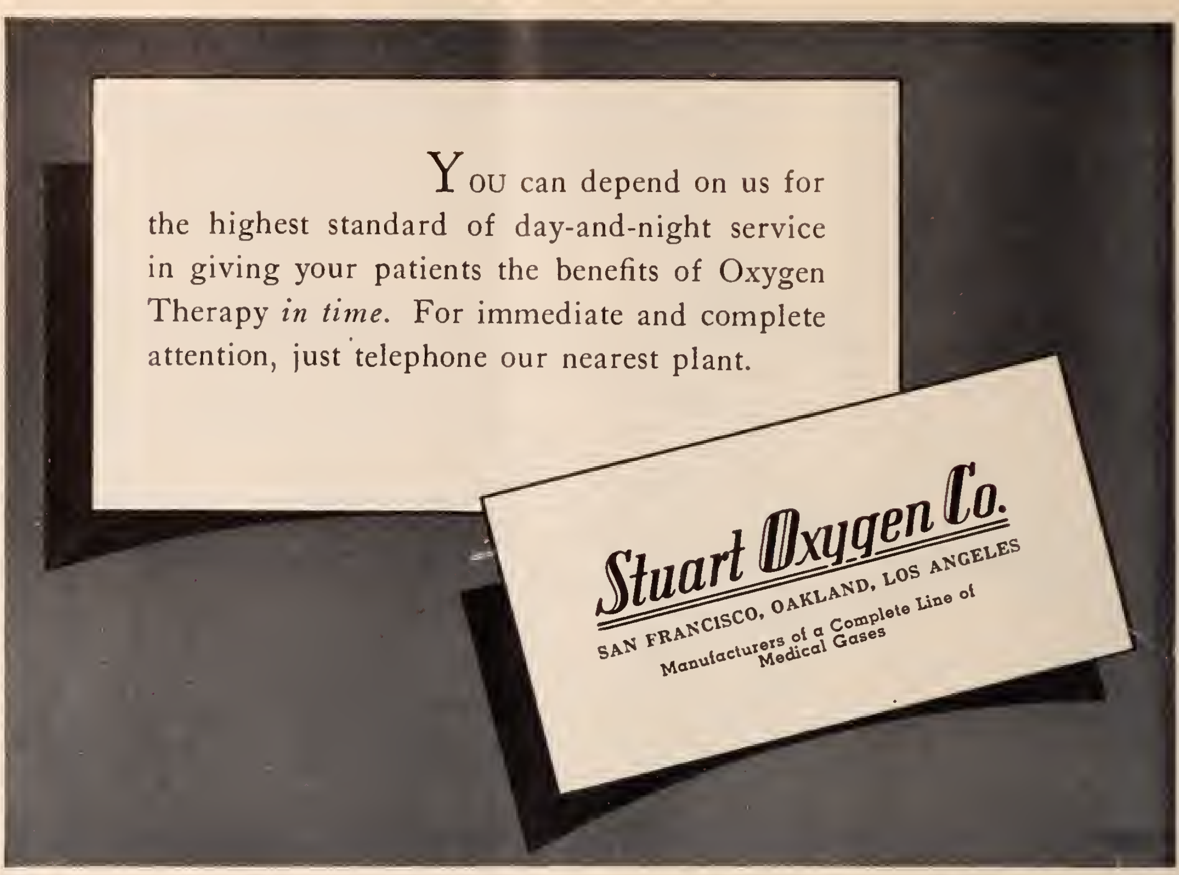
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TWENTY-FIVE YEARS AGO

(Continued from Text Page 276)

From an Article on "The Obstetrical Society of San Francisco: A Reminiscence," by Douglas W. Montgomery, M.D., San Francisco.—When first I came to San Francisco I was asked to become a member of the San Francisco Obstetrical Society, not because I was interseted in obstetrics but because I was then working at pathology. Previous to my joining, it had fallen into desuetude, and the reason for this characteristic and amusing. One of the most prominent men in diseases of women of that day, was an able, bad-tempered Irishman, who managed to quarrel with everyone in the same line of work as himself. On his demise the secretary sent out notices of his death saying that there would be a meeting to frame condolences to the family, and at the same time measures would be taken to resuscitate the society. Subsequent to this propitious reopening announcement, we had many pleasant gatherings, and the crowning point of the evening was always the supper, and at one of these the late Dr. Harry Gibbons told the following story: . . .

From an Article on "Abdominal War Wounds," by Rea Smith, M.D., Los Angeles.—Penetrating wounds of the abdomen causing visceral injury were as a rule fatal on account of the lack of transport, and delays in getting the patient to the operating table. At Evacuation Hospital No. 114, we received patients from 6 to 72 hours after being hit. Many of the cases with abdominal wounds were moribund either from hemorrhage or from peritonitis already well developed. . . .

(Continued on Page 20)

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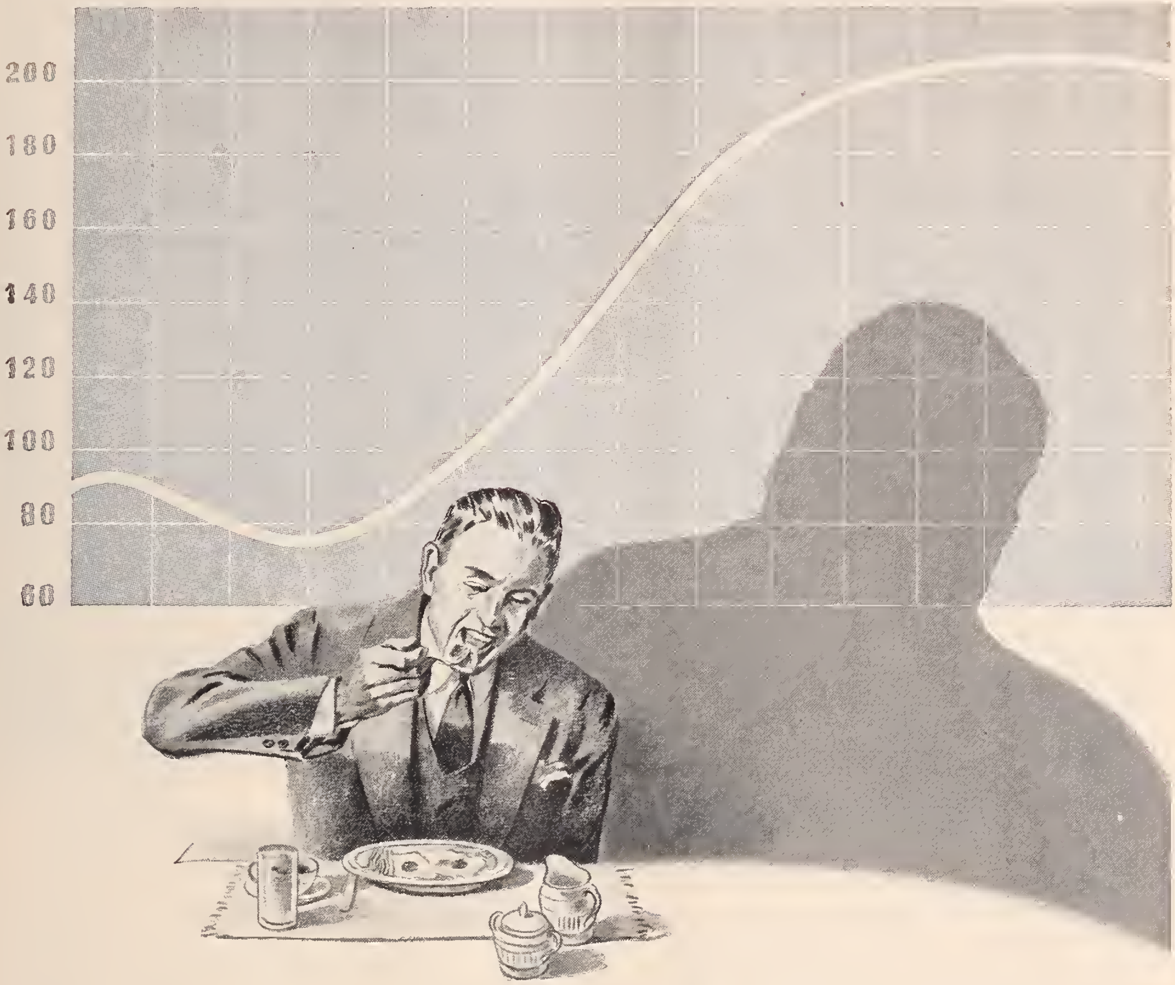

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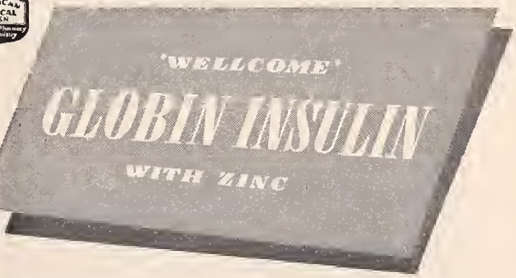

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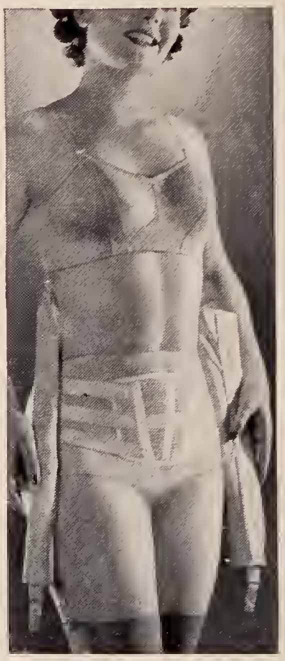

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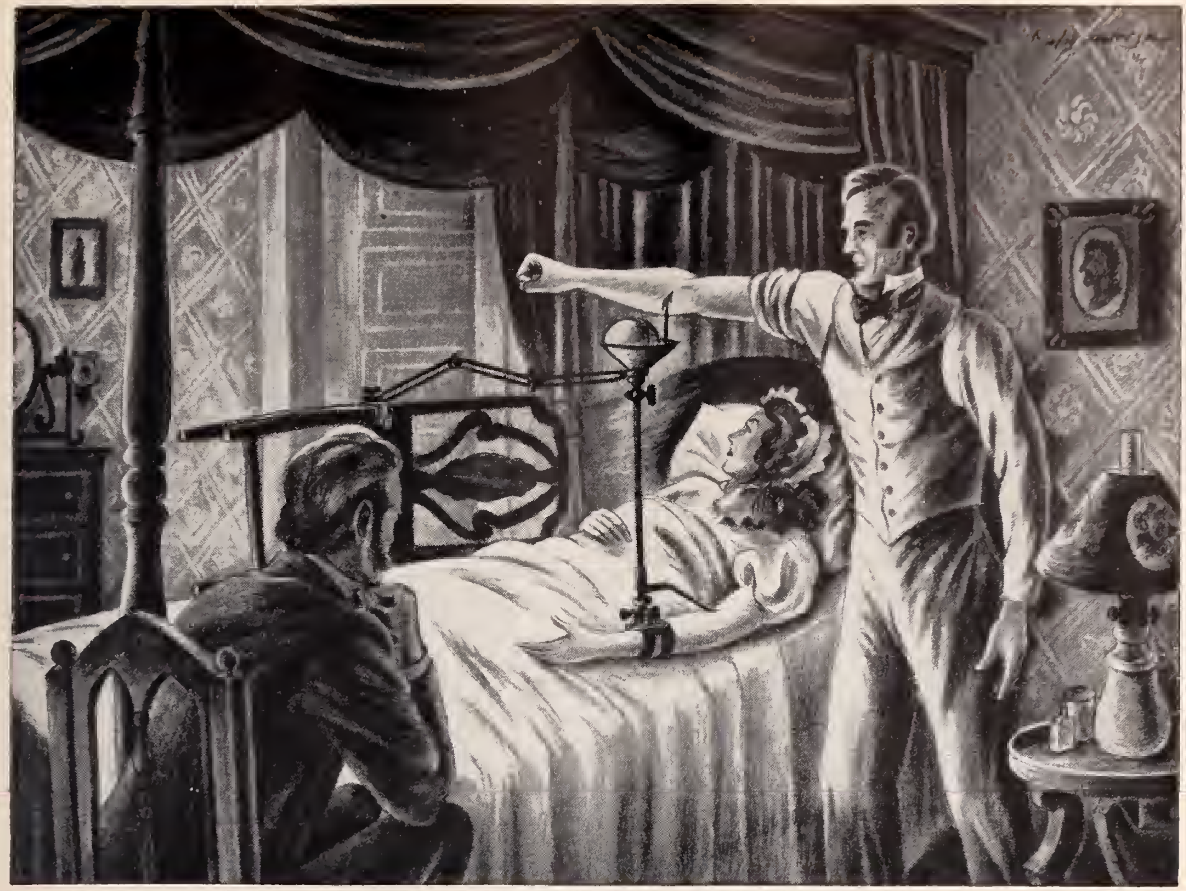

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Crude though it was, James Blundell's experiment was a milestone in medical progress. The difficulties of typing and cross-matching, however, pointed to the need for an acceptable blood substitute. Blood plasma was the substitute of choice, and dried plasma has proved especially satisfactory because it is stable and portable, and because it can be kept for as long as five years without refrigeration.

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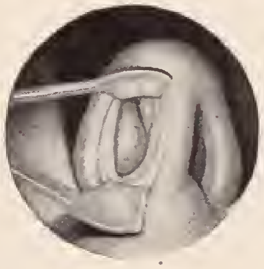
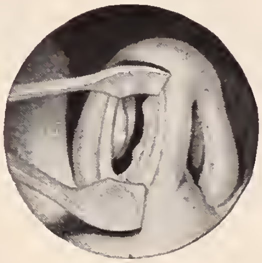


9 MINUTES AFTER TREATMENT

Maximum shrinkage has been obtained with 2 inhalations from Benzedrine Inhaler. The turbinates are contracted. The airway is open.



Butler and Ivy state that—for administering vasoconstrictive drugs—inhalers and sprays are preferable to nasal drops, and are—in most cases—"the better means of nasal medication," because: (1) ". . . the drug reaches the nasal mucosa in more diffuse form . . ."; (2) " . . . the mucosa is never severely ischemic at any one point, but the effect is spread throughout the nasal cavity . . ."; (3) even when prolonged medication is required, there is ". . . far less pathologic change than that resulting from the use of nasal drops."

Arch. Otolaryng., 39:109-123, 1944.

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TWENTY-FIVE YEARS AGO

(Continued from Page 14)

Excerpts from County Society Proceedings: Los Angeles County Medical Association:

Dr. Geo. H. Kress, Vice-President of A.M.A. The Los Angeles County Medical Association and the California State Medical Society were honored in having a member elected from this part of the country by the American Medical Association.

Dr. Geo. H. Kress is dean of the Los Angeles Medical Department of the University of California and ex-president of the Medical Society of the State of California, and was for a long term secretary-treasurer of the Los Angeles County Medical Association and is chairman of the committee on public health of this County Association. He acted as chairman of the California State Commission appointed by the Legislature on the tuberculosis situation of the State.

Dr. Kress is chief of staff of the Graves Medical Dispensary, and is also senior attending eye surgeon at the Los Angeles County Hospital. One of his recent activities was that which had to do with the founding of the League for the Conservation of Public Health, of which he is the vice-president.

Lane Medical Lectures.—The Lane Medical Lectures will be delivered this year by Dr. Alonzo E. Taylor, Professor of Physiological Chemistry at the University of Pennsylvania. Dr. Taylor will speak on the "Feeding of the Nations at War." The Lectures will take place at Lane Hall, on Sacramento street near Webster, San Francisco, at 8 o'clock on the evenings of December 8, 9, 10, 11, and 12, 1919. . . .

(Continued in Back Advertising Section, on Page 30)

Not Lances, but a *Lancet*

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HE's a man of battle. He doesn't charge in with lance atilt—or its modern equivalent the bayonet, the Tommy gun, the Garand—but he's fighting for life, all the same. The lives of other men... and constantly at the risk of his own in those advanced dressing stations and field hospitals. Bombs lash down... shells burst... but he stays at his post.

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COSTLIER TOBACCOS Camels

Reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

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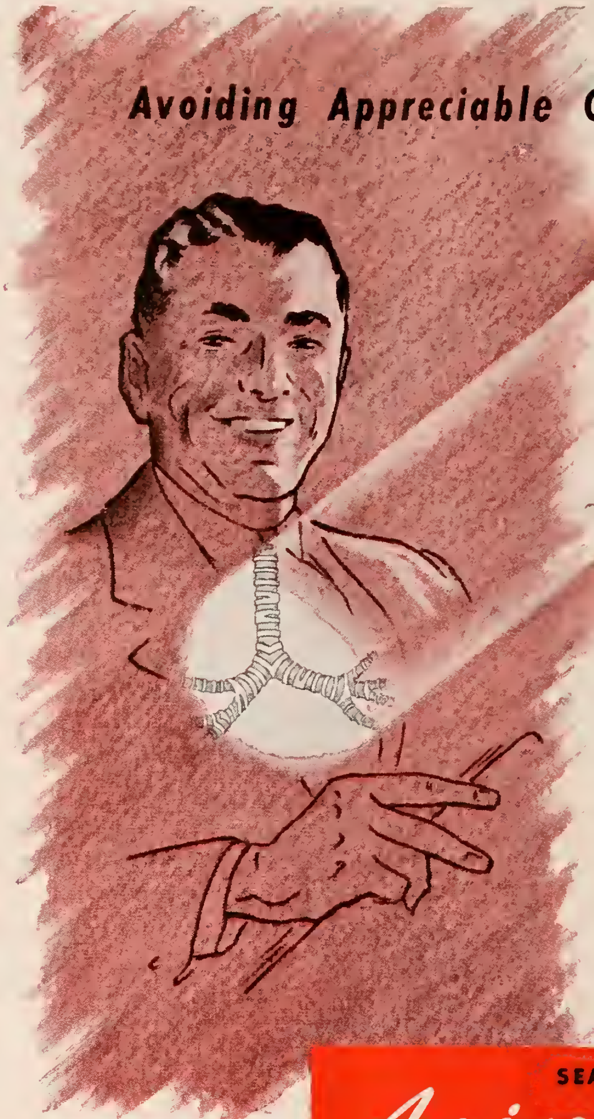

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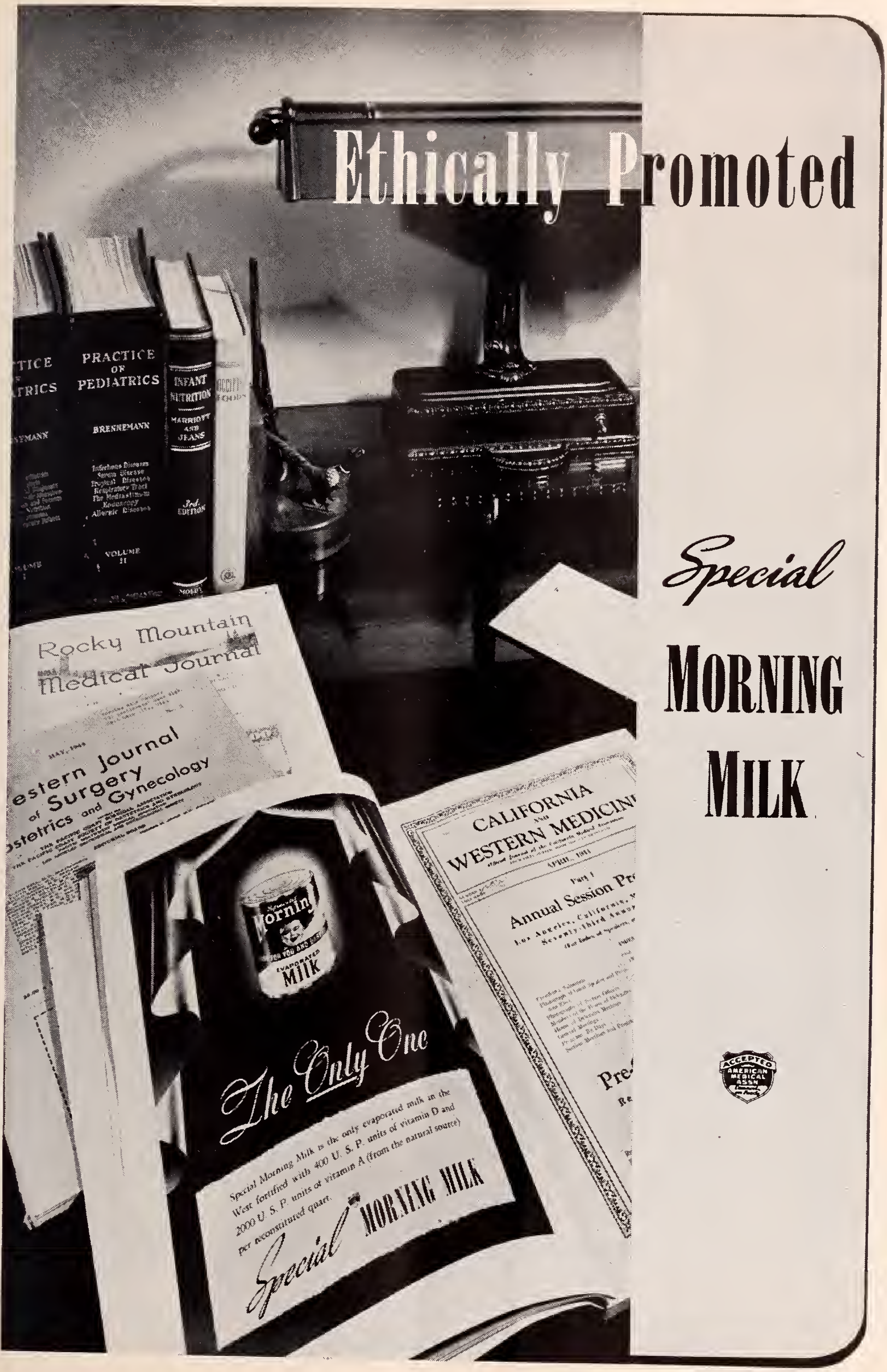
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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

Committee on Publications

Francis E. Toomey..........San Diego 1945
George W. Walker (Chairman)..........Fresno 1946
F. Burton Jones..........Vallejo 1947
Secretary-Editor ....ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . JOHN HUNTON

Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

PUBLIC RELATIONS SURVEY OF CALIFORNIA

Articles by Mr. John R. Little Concerning the Public Relations Survey Made in California in 1943.—Speaking before the House of Delegates of the California Medical Association at this year's annual session, on May 7th, Mr. John R. Little gave an address that appeared in CALIFORNIA AND WESTERN MEDICINE for July.

Mr. Little's talk to the members of the supreme authority of the C.M.A. was received with rapt attention. The applause which followed indicated how fully his remarks had impressed the Delegates. His discussion dealt with factual data that had been uncovered in the survey made by Foote, Cone and Belding, his observations thereon, and suggestions concerning future procedures as based on the information that had been gathered and compiled.

* * *

Recognition of the "Interpretative Report" Was Not Given in J.A.M.A.—In the May issue of CALIFORNIA AND WESTERN MEDICINE appeared Mr. Little's "Interpretative Report," its statistical and other information being of special value because of its source, character and the excellent manner in which the summaries and other implications were portrayed. Nevertheless, the *Official Journal* of the American Medical Association gave no notice thereto, simply listing the title of the article. This non-attention by *J.A.M.A.* to a report that was worthy of perusal by physicians throughout the land who are interested in public relations of the medical profession, explains why CALIFORNIA AND WESTERN MEDICINE in its issue of September made editorial comment under the caption, "A Lapse of Memory, or What?",—the comments ending with these paragraphs:

"It will be interesting to note whether Mr. Little's illuminating and very valuable article, 'Public Relations Survey of California,' in the July issue of CALIFORNIA AND WESTERN MEDICINE will receive major, minor, or no comment in a future number of the *Official Journal* of our national organization—The American Medical Association.

"If no comment, why not?"

It is not known whether the above query had aught to do with the editorial which later appeared in the *Journal of the American Medical*

Association in its issue of October 7, under the caption, "The Public Relations Survey of California."

Appreciation is expressed, however, for the attention that was drawn through it to the survey that had been authorized by the Council of the California Medical Association.

However, since the comments by the editor of the *Journal of the American Medical Association* may not have given to many readers a clear impression of Mr. Little's article or the recommendations contained therein, further comment is here made.

* * *

What Mr. Little's Introduction Aimed to Portray.—The opening paragraphs of Dr. Morris Fishbein's editorial would lead the unwary reader to believe that Mr. Little found it necessary to use several pages to justify the California Medical Association's expenditure of $8,000 for a survey; particularly after a survey in other States conducted at the instance of the National Physicians' Committee had previously brought out similar facts. As a matter of fact, the California survey was conducted in November, 1943, the N.P.C. report coming out some months later.

A fairer portrayal of Mr. Little's opening remarks would be a statement that serious public relations problems involving governmental agencies and supervision, had come up in other fields than medicine, and the problems had been solved. A specific California example—the chain store experience of 1935,—was cited at some length by Mr. Little.

* * *

Public's Attitude and Reservations Regarding Pre-Payment Medical Care Plans. — Dr. Fishbein states the N.P.C. survey indicated,—"The public does not object to prepayment plans."

If Dr. Fishbein had scanned Mr. Little's Interpretative Report as given in CALIFORNIA AND WESTERN MEDICINE for May, or the complete 232-page report, several copies of which were sent to the A.M.A. offices, he might have phrased his words otherwise, so that the impression would have been given, that the public not only does not object to prepayment plans, but citizens seem to prefer such; provided, however, that at reasonable cost, the traditional doctor-patient relationship will be maintained in such plans.

Editor Fishbein continues: "In California it [the public] did apparently object to the prepayment plan then being conducted by the California Physicians' Service."

In regard to the above quotation, it may be stated that the great majority of citizens of California do not object to California Physicians' Service as a medical care plan. The major objections that have been raised have come not from citizens, but from members of the medical profession; and further, these objections have rested not on grounds related to the general prepayment plan of C.P.S., but rather on the business administration as it was conducted during the formative and experimental years of C.P.S.

Mr. Little's propositions, that C.P.S. should aim to cover between 3,000,000 and 5,000,000 people in California, and that its administrative procedures, other than professional, be conducted in line with the "finest standards of American business" were seemingly well received by the members of this year's C.M.A. House of Delegates.

* * *

Physicians Have Much to Learn Concerning Public Relations Related to Medical Care.—Concerning relations of the medical profession with the public, most California physicians feel there is still much to learn, but this lack of understanding is not confined to California. The entire medical profession of the United States has still a vast deal to learn concerning better public relations. Perhaps, many of the unfortunate happenings of recent years rest in considerable measure on rather poor understanding of public relations, a fact that may explain why some American Medical Association authorities recently have received so much criticism from various sources.

* * *

Misinterpretation Concerning Sympathy with Medicine's Ideals.—In his second paragraph, Dr. Fishbein refers to long accepted ideals of fundamental character concerning medical practice. However, he concludes his thought: "Economists, sociologists, business executives and insurance agencies seem to have had but little sympathy with these ideals in the past. Mr. Little, in his recommendations to the California Medical Association, follows the line long emphasized by Michael Davis, Isadore Falk and others."

In tying Mr. Little up with "Michael Davis, Isadore Falk and others," and what they supposedly advocate, it is proper to state that Mr. Little did not recommend such procedures, but did suggest to the constituted authorities of the California Medical Association that the general business administration of C.P.S. be responsible to a Board of Directors composed of doctors representing organized medicine in California who would pass on matters of policy. Furthermore, it was stated that the administrator also have under him a man who would be responsible for doctor relations, that executive to be a physician.

* * *

On What the C.M.A. Has Done to Make Mr. Little's Recommendations Effective.—Dr. Fishbein's second paragraph ends with the sentence: "Exactly what the California Medical Association will do to make Mr. Little's report effective is not yet apparent."

It is possible that the editor of *J.A.M.A.* did not have time to note what was done at this year's C.M.A. annual session, as given in the minutes of the meetings of the House of Delegates, and of the C.P.S. Administrative Members, (the C.P.S. meeting being under the Chairmanship of Dr. Ray Lyman Wilbur), and as printed in California and Western Medicine for July.

It is possible that, had request been made, the A.M.A. Bureau of Medical Economics, also located at 535 North Dearborn Street in Chicago, would have been in position to give the *J.A.M.A.* editor a clearer orientation concerning these matters.

The changes authorized by the C.M.A. House of Delegates in May last, for better administration of C.P.S., rested in considerable part upon information presented by Mr. Little. So that much has already been done to make some of the recommendations effective.

* * *

On Availability of High Quality Medical Service at Low Cost.—In his third paragraph, Dr. Fishbein talks about "trends" and what a medical philospher of long ago said thereon, and then expounds thusly:

"If there were but one way in which the people could secure a high quality of medical service at a low cost, the problem of the medical profession at this time would be exceedingly simple. There are, however, many different approaches to this problem. There is the former technique of the California Physicians' Service and the changed plan. There are similar but in some respects different plans already in effect in other states. There are the techniques now being developed by a variety of private insurance agencies in coöperation with large industries. There is the plan of Mr. Henry Kaiser. There is the possibility of compulsory sickness insurance on a county, a state or a national basis."

Commenting on the above, it may be said that few reasonable people believe that "the problem of the medical profession at this time" *is* simple. Some realistic and thoughtful people within the profession do believe, however, that it *is solvable*. Certainly most human progress is through evolution. Physicians are reluctant to believe that evolution is impossible in the great humanitarian urge of doctors to provide even better medicine to larger numbers of people. Through the use of evolutionary methods, even though some of the experience must be acquired the hard way, through trial and error, the California Medical Association has been making a sincere effort to make available for low income groups, good quality medical care at reasonable cost.

* * *

California Medical Association Has Given Much in Both Thought and Money to Improve Medical Care Facilities.—As should be well known even at A.M.A. headquarters, the members of the California Medical Association, after some years of earnest discussion, and expenditure of from fifty to seventy-five thousand dollars, worked out the statewide prepayment plan now operating as California Physicians' Service. It is the hope of the medical profession of California that as C.P.S. grows in number of members and strength, it will be able to continue to give a high quality of medical service at reasonable cost as provided by the patient's own personal physician, and with maintenance of the principle that medical ethics and standards are strictly the prerogatives of doctors themselves.

* * *

Editor Fishbein's Erroneous Conclusion.—Dr. Fishbein concludes his editorial with this statement: "The most important fact that comes out of Mr. Little's survey is that people in California were not satisfied with the California Physicians' Service up to the time of his survey and that changes seemed to be necessary to satisfy the people. Whether these changes when made will be satisfactory will remain, of course, for time and the California Medical Association to determine."

Fortunately, as regards the point of view of most California physicians, it may be said they do not concur in Dr. Fishbein's pessimistic interpretation of Mr. Little's report, or the implied opinion that California Physicians' Service has failed. Reference to the C.P.S. report in the current issue shows that in the month of October 20,000 new members were added to the roster of beneficiary members, of whom there are now some 103,475, and that C.P.S. as a business organization has now an annual gross income of some $1,500,000. Other reports in recent issues, on the lessons learned in five years of operation, with activities for which, in the beginning, there was practically no actuarial information for guidance, give additional information on the excellent progress that has been made.

Therefore, even though Editor Fishbein seems somewhat downhearted or pessimistic about California Physicians' Service, for that is at least the transient impression given through its perusal—most of the physicians of California take pride in its achievements, and hope its experiences will be of aid not only to the profession of California, but to other State and local medical organizations throughout the United States.

PAY PATIENTS IN COUNTY HOSPITALS OF CALIFORNIA: SOLUTION PROPOSED BY ATTENDING STAFF OF LOS ANGELES COUNTY HOSPITAL

Interesting Article on Los Angeles County Hospital Plan. — California and Western Medicine, in its issue for September, 1944, on pages 158-159, printed an article, "The Los Angeles County Hospital and the Lanham Act," taken from the *Bulletin of the Los Angeles County Medical Association.* The article is worthy of perusal by all members of the California Medical Association, since the functions of county hospitals in relation to "pay-patients" (non-indigent patients) has been a problem that has received much discussion in the last 25 years or so, by both component county medical societies and the State Association.

Legal Background of County Hospitals.—Before making comment on the Los Angeles plan, it may be well to remind readers of some fundamental legal facts bearing on the question, "Shall non-indigent patients be admitted into county hospitals that are solely supported by tax-payers?"

In California, the 58 constituted counties are legal entities and units of the commonwealth. These counties are governed by Boards of Supervisors, most often consisting of five members. A legal obligation of each Board of Supervisors is the protection of the health and lives of indigent citizens. To care for serious illnesses and injuries of indigent citizens, county hospitals have been established.

For many years, especially in the days when, in legal nomenclature and the press, the "pauper" appellation had not been discarded for the more euphonious term, "indigent," most of the county hospitals limited themselves to service for the penniless group of citizens. During that period the capital outlay in buildings and equipment was not of a kind to be attractive to citizens who could secure the services of a physician in private practice (even though, ofttimes, the physician received little or no actual pay).

However, as time went on, and as communities grew in population, many of the county hospitals likewise increased in size and facilities. In some counties, full time and well-qualified medical personnel was placed in charge. Under these conditions, with up-to-date county hospital buildings and equipment, and improved medical service, a not inconsiderable number of citizens began to clamor for county hospital care. So gradually, in some California counties, the strict limitation that county hospitals should function only for service to indigent citizens broke down.

Solution of the problems related to entrance qualifications for county hospital service has not been easy, because local environments bring different factors into consideration. For instance, in San Francisco County, the Medical Schools of the University of California and Stanford University have special arrangements. In Los Angeles County, the two medical schools work under a different system. In other places, Alameda for instance, and in Sacramento, San Diego and Fresno and other counties, altogether different conditions obtain. Wherefore, it is understandable why no one solution of the pay-patient problem has been found that will answer the needs of each and all.

So much in the way of foreword concerning the new Los Angeles County Hospital plan to have non-indigent patients pay for professional services rendered in the County Hospital, when same have been given by physicians of the attending staff.

* * *

Other Data Concerning the Los Angeles County Hospital.—Leaving out of discussion the smaller counties organized in the gold rush, forty-niner days (one California County—Alpine—well populated in the mining days, now has a total population of about 241 citizens!), let us consider the *Bulletin* article that makes special reference to the Los Angeles County Hospital. The main division of that institution is today one of the largest hospitals in the United States; and in addition to a large full-time medical personnel, has an attending staff of some 600 members who give their services without cost to either the County or patients. The average daily in-patient load is about 2,446, assuredly a large number of patients.

Under wartime and emergency conditions, with private and semi-private hospitals filled to overflowing, it has not been possible in Los Angeles to limit admissions to indigents, or to the closely related group, now-a-days referred to as "medically-indigent" (persons with financial means sufficient to provide food, clothing and housing, but who possess no reserves for care of ill health or injuries).

* * *

How the Attending Staff of the Los Angeles County Hospital Is Attempting to Solve the Problem.—As stated, the 600 members of the Los Angeles County Hospital have been happy to give their gratuitous professional services to the indigent and medically-indigent groups, but the attending physicians and surgeons have long felt it was not fair for a wealthy county, such as Los Angeles, to require them also to give free medical care to citizens who possess financial resources, sufficient to enable them to engage the services of physicians in private practice.

The procedure through which the staff of the Los Angeles County Hospital, the constituted authorities of the institution and the County Board of Supervisors, have attempted to solve this problem can be understood by reading the following excerpts from the article to which reference has been made:

> . . . After studying the matter thoroughly the committee recommended that the hospital administration establish a program whereby fees for hospital care and for medical and surgical services would be collected from this class of non-indigents. It was further recommended that such fees should not be paid to the individual staff physicians rendering the services, but placed in a special research fund to be administered jointly by members of the two medical schools. It was advised that non-members of the staff of the hospital be not permitted to care for patients in the hospital because of administrative difficulties and interference with the program for training medical students, interns and resident physicians. The recommendations of the committee were adopted by the Medical Advisory Board without any dissenting vote. . . .
>
> This committee held several meetings and received suggestions from many different sources. Its report was approved by the Medical Advisory Board on June 15, 1944, and the hospital administration was requested to establish the fiscal mechanism for collecting such fees and allocating them to the special committee known as the "Medical Research Fund of the Los Angeles County General Hospital." Dr. Burrell O. Raulston, dean of the University of Southern California School of Medicine, and Dr. W. E. Macpherson, dean of the College of Medical Evangelists, have been named co-chairman of the research committee which will administer the fund.

At the conjoint meeting of the medical and surgical staffs of the General Hospital which was held on Monday, June 26th, Dr. Bayley presented the work of his fee schedule committee with a statement that it had been approved by the Medical Advisory Board. After some discussion, the proposal was unanimously approved by the staff. . . .

THE FEE SCHEDULE:

General Medical Care—$5.00 per day with certain limitations by the hospital management upon this fee when a patient is confined for an unusually long time in the hospital.

Surgical Fee—Surgical and obstetrical procedures are to be classified into major and minor operations, and, in turn, major and minor operations are subdivided into groups A, B, C, and D:

Major Operations		Minor Operations	
A	$250.00	A	$100.00
B	200.00	B	75.00
C	150 00	C	50.00
D	100.00	D	25.00

A special stamp bearing the classification Major or Minor A, B, C, D, will be furnished by the hospital and imprinted upon the operative record of each patient. Following an operation the surgeon in connection with his dictation to the surgical stenographer will merely dictate his classification of procedure; that is, a difficult laparotomy such as gallbladder, resection of stomach or intestinal anastomosis, would be classified as Major A. It is believed that all procedures within the hospital can be appropriately classified in this manner. It is believed that the committee's plan to use this simple classification will be much easier in practical application than a fee schedule. . . .

A few words of comment may be in order concerning the general philosophy underlying this program. There was some thought on the part of the hospital management that the schedule as outlined is too high. The fee schedule committee felt very strongly that this schedule should represent only a reasonable minimum fee for the procedures contemplated. It must be borne in mind that once such a schedule is used it is quite likely to be quoted in court procedure as a basis for establishing the value of medical and surgical services and thus, it should not be too low. It was understood that when such a schedule imposes hardship upon any patient the hospital management will not press for collection. Certainly the rendering of a bill covering medical care will serve the salutary purpose of informing a patient that services of value have been rendered. It is doubtful that legal attempts at collection will be made or would be desirable. . . .

* * *

County Medical Societies Should Keep in Touch with Their County Hospitals.—What has been noted above should be sufficient to lead attending staffs of other county hospitals in California to consider similar lines of procedure. If one County can make arrangements, other counties likewise should have the same legal rgihts.

Other phases of the subject could be discussed, if space were available. This present comment is made to express the hope that county medical societies throughout California will continue to maintain active interest in the manner in which their respective county hospitals carry on their work. The members of County Societies owe much active interest not only to their fellow citizens, but to their profession.

EDITORIAL COMMENT†

HEREDITARY SPERM GROUPS

Applying the common procedure for the demonstration of hereditary blood groups in domestic animals, Snell[1] of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine, has demonstrated hereditary antigenic groups in the sperm cells of mice. Thoroughly washed pooled spermatozoa from the vasa deferentia and epididymides of male mice of the same inbred family were injected intraperitoneally into female mice of a different inbred family. From 7 to 14 days after the 12th to 20th injection, the injected mice were bled. The resulting antiserums were freed from antibodies common to all family groups by absorption on the sperm cells of a third inbred mouse family. Parallel agglutination tests were then made with the resulting reduced antiserums, using motile sperms of the 4 different inbred mouse strains. Agglutination tests were run in the hanging drop, reading, usually being made at the end of from 15 to 30 minutes. In ++++ agglutination practically all sperms were stuck together in mats or clumps. Adhesion was usually by the tails or middle pieces. There was no reduction in motility. Of the 4 reduced antiserums thus far tested, one gave ++++ agglutination sperms of the homologous family, with practically no cross reactions with heterologous sperms. Two of the reduced antiserums, however, gave minor cross-agglutinations. One antiserum was prepared against spermatozoa of a hybrid family. This serum gave +++ reactions with spermatozoa from each of the two ancestral families. The results of these and other tests led Snell to conclude that there are at least two hereditary antigenic sperm groupings in the 4 inbred families thus far tested. The relation between hereditary sperm grouping and hereditary blood groupings has not yet been determined.

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REFERENCE

1. Snell, George D., Science, 100:272 (Sept. 22) 1944.

INTRACISTERNAL SERUM THERAPY

In tetanus the development of the pathologic process may be prevented by specific antitetanic serum injected subcutaneously prior to the appearance of symptoms. After symptoms develop such antiserum even if given in massive doses intravenously or by lumbar puncture is ineffective in the majority of cases. Soviet military physicians have therefore tried a new method of antitetanic serum therapy, that of injecting the antiserum directly into the cisterna magna. The method is an application of early observations by Roux and Borrel[1] who found that doses of tetanus antitoxin absolutely powerless to arrest the progress of experimental tetanus if administered subcutaneously, readily cured the disease if injected into both hemispheres of the brain. The new Soviet method was first perfected by Stern[2] of the U.S.S.R. Academy of Science, on experimentally infected dogs, and afterwards applied to the treatment of natural tetanus in horses. She found that even severe forms of equine tetanus can be cured when an adequate dose of antitetanic serum is injected into the cisterna magna. The method was then tested on human subjects. With the patient in a modified Trendelenburg position with chin on sternum, the needle is inserted at an acute angle between the external occipital protuberance and the spine of the atlas. From 10 to 20 c.c. of cerebrospinal fluid is then withdrawn and replaced by an equal volume of warmed antitetanic serum. A series of 6 typical cases are reported by Stern. In the most refractory case 30,000 American units of tetanus antitoxin was injected intramuscularly and 15,000 units by cisternal puncture, the dual injection being repeated daily for four days. Improvement was noted within 24 hours after the first injection, with complete and uneventful recovery by the 14th day. In most cases but two, combined intramuscular and intracisternal injections (9000 to 15,000 units) were required for full recovery. No failure to effect a complete cure and no untoward effects of the new technique are thus far reported. To American physicians Stern's work is mainly of theoretic interest, since to date there has not been a single case of tetanus in the United States Army or Navy. Our immunization has evidently been extremely effective.

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

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REFERENCES

1. Roux, E. and Borrel, A.: Ann. d. l'Inst. Pasteur, 12:225, 1898.

2. Stern, Lina S.: Amer. Rev. Societ Med., 1:540 (Aug.), 1944.

("Tuberculosis in Wartime." Concluded from Page 255)

the sanatorium before they should, with a positive sputum. They work, to their own detriment, while they spread the disease. The splendid work which Dr. Edward Kupka, Chief of the State Bureau of Tuberculosis, has done in calling this matter to the attention of health officers and others interested in the solution of the tuberculosis problem is, in no small measure, responsible for the widespread enforced isolation of the tuberculous in California. Health authorities are authorized to quarantine active cases of tuberculosis according to the Health and Safety Code, and in many cases this should be done. Certainly a solution of the tuberculosis problem need not wait until the return of peaceful conditions. It is even more important now to continue our efforts to combat tuberculosis while the disease is diminishing and while so many potential elements exist which might lead to an increase in the morbidity and mortality rate if our well-known health measures were relaxed.

490 Post Street.

We Need a Book: On "Socialized Medicine"

The following thought-provoking editorial comment appeared in a recent issue of the *Journal of the Michigan State Medical Society:*

Not long ago one of our leading physicians asked the editor of the *Journal of the Michigan State Medical Society* for references to a book that would give the status of the problem of socialized medicine, the arguments for and against regimentation and state medicine, and what can be done about it. He wished to study the subject in all its aspects, from both sides, and then to be able to formulate some conclusions for himself. Later the director of one of our industrial high schools asked for a list of information that could be set out for students who wish to work on this subject in their debates and other studies. Very recently the wife of one of our members who is serving as a Captain in the Army overseas, wrote to the Lansing office asking what, if anything, the medical profession is doing to counter the urge for regimentation. She said her husband had asked that she keep in touch and keep him informed. She was of the opinion that nothing is being done. . . .

The Michigan State Medical Society, in conjunction with the Michigan Department of Health, the Wayne University Medical School, and the University of Michigan Medical School, has made one of the most progressive and far-reaching experiments in bringing postgraduate medical studies to the private practitioner of medicine. In no place in the world has postgraduate medical study even matched what has been done in Michigan. Postgraduate medical study is certainly one of the necessary things needed to bring to the people the very best in medical care. The Michigan State Medical Society has also established a Foundation for the advancement of postgraduate medical study. This has all been accomplished by voluntary, not compulsory effort.

Plans for the postwar world of medicine, plans for the mental rehabilitation of our doctors in military service, plans for the preservation for our people of the individual and voluntary administration of medicine, the plan which is fundamentally and wholly American, have occupied the time and effort of our administrative bodies at and between every meeting for years. Many of us have advocated more intensive contacts with the public in the way of keeping them informed concerning what American medicine is, what it has done for the health and well-being of the country, and what the future may look for under private enterprise, as well as under regimentation.

We need a book.

Someone must write a book to place this information in the reach of high school children who are asking for authentic knowledge. That book should tell what the practice of medicine is, the problems of education, the problems of distribution, the problems of research, the problems of coöperation, of consultation, of giving our people not just good medicine, but the very best that is known. That book would also be a good place to paint the picture of regimentation, of bureaucracy, of cultism.

Someone *must* write a book.

And that book should be placed gratis in every public library in the State, in every high school and college reading room in the State, in the hands of every teacher of social problems in the State, in the hands of the directing head of every educational institution in the State, and lastly in the hands of every doctor of medicine in the State.

Who will write this book?

How soon?

A tragic epitaph for certain victims of shock: "Too little, too late."

ORIGINAL ARTICLES

Scientific and General

COMMUNICABLE DISEASES IN WAR TIME†*

Edward B. Shaw, M. D.
San Francisco

Foreword.—This region on the Pacific Coast has enjoyed an increasingly favorable position with respect to the incidence of communicable disease. Public Health administration has been enlightened and vigilant; the production and distribution of milk, food and water have been effectively safeguarded; quarantine and isolation have been adequately enforced to effect significant reduction of contact infection. Poverty, filth and congestion of population have not, in general, constituted problems of very adverse importance.

It is almost inescapable that the problems engendered by war time should disturb any existing feeling of complacency regarding the many problems of infectious disease as they affect the public health and the responsibility of private practitioners of medicine. Personnel shortage may conceivably threaten the effective inspection of food and drink, and the enforcement of quarantine measures. Importation of civilian workers, many of them from less-favored areas, has introduced large numbers of children and adults unprotected by specific immunization, among whom contact infection may be expected to be more prevalent. The abrupt increase in population has also introduced the important factors of crowding and faulty housing which would be expected to accentuate certain of these disease problems. Increased incidence of communicable disease from this source, should it develop, would constitute a much more critical test of the effectiveness of artificial immunization among our normal population, and of the protective function of control measures heretofore effective, than would be anticipated if we had remained without this adventitious source of exposure.

Troop movements afford an additional factor to complicate our situation. Certain infections, notably meningococcus disease, frequently are increased in the vicinity of troop concentrations. Among the armed forces are those of variable susceptibility, and these include both latent and active infections of the commoner diseases, as well as more rare infections with which the average physician is relatively unfamiliar.

PURPOSE OF SYMPOSIUM

It is the purpose of this symposium to present as succinctly as possible a discussion of the more urgent problems of communicable disease which may be expected to confront the physician during this emergency period.

Before passing to a discussion of these various infections it may be worthwhile to emphasize the importance of the continuation of routine immunization early in childhood against those diseases in which this practice is effective. It is the writer's opinion that the private physician is the most important factor in accomplishing this. Only the physician is in contact with the child of less than school age, during the years when protection is most readily afforded with a minimum of adverse reactions. Public health and school health activities concentrate on the child of school age, leaving unprotected the younger children of greater susceptibility.

Various *ex cathedra* sources are responsible for numerous and different recommendations regarding the exact measures which should be employed routinely, and at what age, interval, preparation and dosage these should be given. There is sufficient diversity to justify an individual opinion.

Pertussis. Whooping cough is most serious and fatal in early infancy. The infant should accordingly be immunized as early in life as a dependable immunity can be effected. An acceptable routine is the administration of pertussis vaccine in a total dosage of 100 000 million organisms, divided into three doses, given at intervals of 2 to 3 weeks early in the second half year of life.

Diphtheria. Relatively rare in early infancy, diphtheria is most fatal in early childhood. Immunization may suitably be deferred until one year of age to secure maximum immune response. Plain toxoid, alum ppt. toxoid or aluminum hydoxide adsorbed toxoid may be used in doses of ½, 1 and 1 cc. at intervals of 4 to 8 weeks (three doses).

Tetanus. Immunization against tetanus is somewhat less necessary and useful than the foregoing, but is effective and desirable. It is appropriate to use tetanus toxoid in combination with diphtheria toxoid, which does not reduce the effectiveness of either immunization and does not increase reactions.

Smallpox. During epidemics vaccination may be done at any age, but if performed in early infancy it should be repeated at the end of one year. Under ordinary conditions vaccination should be routine during the second half-year, or shortly thereafter.

Recall immunization. Once a basic immunity is established by a series of immunizing injections, the immunity may be periodically reinforced, especially under conditions favoring exposure, by single injections of the immunizing agent. Pertussis immunity may thus be stimulated by single injections every one or two years, or at other times when exposure exists or may occur. Immunity against diphtheria should be determined by means of the Schick test 6 months after immunization, and again at first school attendance. The Schick test alone serves somewhat to augment a basic immunity, and additional toxoid injections may be indicated by the Schick response. Tetanus immunity should be recalled by a single injection of toxoid in the face of suspicious injuries, or may be similarly stimulated at intervals of one to two

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† **Explanatory Note.** Concerning Four Symposia to appear in issues of October, November, December and January.

In every war there is a tendency to neglect the health, the safety, and the nutrition of those who are behind the lines. Famine and pestilence are facts of war and can be crucial factors in victory or defeat. Our present war is so large and is lasting so long that we will need to be especially alert well beyond the cessation of hostilities.

With the desire to promote optimal health in our civilian population four symposia have been compiled. These have been gathered as follows: (1) Symposium on Disaster Relief, by Henry Gibbons, III of San Francisco, appeared in October issue; (2) Symposium in November issue, on Communicable Diseases, by Edward B. Shaw, of San Francisco, appears in current issue; (3) Symposium in December issue, on Nutritional Problems, by Dwight L. Wilbur, of San Francisco; (4) Symposium in January issue, on Industrial Medicine, by Rutherford T. Johnstone, of Los Angeles.

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* Foreword to several papers in a symposium on "Communicable Diseases." Papers in the symposium have been collected by Dr. Edward B. Shaw, San Francisco.

years if there is frequent likelihood of exposure. Smallpox immunity should be repeated at intervals of 5 to 7 years, or during epidemics. The presence of immunity is confirmed *only* by the production of an "immune reaction" (the papule which appears at the end of 48 hours and disappears before one week). This immune response further stimulates the existing immunity.

Numerous other immunization measures are not presently appropriate to our civilian problems. Only exceptionally, during epidemics, is there need in this region for routine immunization against typhoid in urban communities. Measures of public health and sanitation are generally more acceptable in the control of typhoid than routine vaccination.

* * *

The papers which follow will deal with the problems of management of the communicable disease,—problems which are most important at this time.

COMMUNICABLE DISEASE TRENDS IN CALIFORNIA†

Wilton L. Halverson, M.D.
Harlin L. Wynns, M.D.
San Francisco

THE incidence of certain types of communicable disease has dropped so rapidly during the last three decades that, in many instances, schools of medicine and nursing find it difficult to secure suitable teaching material.

The relative importance of factors and forces responsible for this cannot be sharply delineated. Advances in medical science, more adequate preventive, diagnostic, and therapeutic procedures by the practitioner of medicine, and the development of control measures on a community basis have all played a part. In some instances better living conditions have been by far the most important factor.

The following tabulations of cases, deaths, and rates for certain important communicable diseases indicate, however, that there still remains an important control problem in many areas.

DIPHTHERIA AND SMALLPOX

These diseases have been reduced principally by immunization procedures. States whcih have compulsory vaccination laws have no smallpox. California, which has depended on voluntary vaccination, has continued to have epidemics from time to time.

It is not necessary to have 100 per cent of the susceptible population immunized to prevent outbreaks of diphtheria. Godfrey* showed that if approximately 50 per cent of elementary school children, and, in addition, 30 per cent of preschool children were protected, the disease would not occur except sporadically in any community.

This is probably true under present conditions; but if diphtheria were as virulent now as it was half a century ago, it is likely that it would be necessary to immunize many more than 50 per cent of the susceptible population to prevent the occurrence of the disease.

The aggregation of individuals in a community is also an important factor. In a densely-populated tenement district, the possibilities of the spread of infection are much greater than in a village or small town.

Danger of the spread of disease would be much greater should we transplant into a tenement area thousands of rural families. This is, in effect, what has been done in certain of our war production centers in California, and it is of the utmost importance that we immediately immunize a safe percentage of these transplanted children.

Diphtheria case rates have fallen steadily until 1942, when there was a moderate rise. The year 1943 shows a continuation of this upward trend (Table 1). Thus far, war production centers have not experienced epidemics of this disease, but a dangerous condition exists in these areas.

There has been no appreciable drop in the diphtheria case fatality rate (Table 3). It is also an interesting fact that, with the increased protection of children, there

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† One of several papers in a symposium on "Communicable Diseases." Papers in the symposium have been collected by Dr. Edward B. Shaw, San Francisco.
From the California Department of Public Health.

* Godfrey, Edward S., Jr., M.D., "Practical Uses of Diphtheria Immunization Records," American Journal of Public Health, August, 1933, p. 809.

Table 1.—*Reported Cases** of Certain Communicable Diseases*

Disease	1920-1929*	1930-1939*	1940	1941	1942	1943
Diphtheria	7,052.7	2,243.1	893	763	882	1,167
Measles	19,972.2	34,525.0	12,360	16,069	122,822	21,134
Meningitis (Meningococcic)	233.6	202.0	68	87	207	927
Pertussis	6,009.2	12,741.4	15,824	21,344	13,491	14,335
Poliomyelitis	364.1	898.2	440	237	327	2,649
Scarlet Fever	7,649.0	8,768.2	5,877	5,327	4,935	7,157
Smallpox	3,602.1	959.4	105	14	7	4
Tuberculosis (All Forms)	9,434.8	9,045.2	7,748	7,509	7,619	7,879
Typhoid Fever	960.0	582.4	304	235	150	164

* Annual average.
** Cases and deaths among military forces excluded.

Table 2.—*Death Rates of Certain Communicable Diseases** per 100,000 Population*

Disease	1920-1929*	1930-1939*	1940	1941	1942	1943
Diphtheria	9.6	2.1	1.1	0.83	1.2	1.2
Measles	3.1	1.6	0.14	0.14	1.4	0.36
Meningitis (Meningococcic)	2.2	1.5	0.24	0.31	0.84	1.9
Pertussis	6.2	2.4	1.5	1.6	1.5	1.3
Poliomyelitis	1.5	1.0	0.63	0.30	0.38	2.0
Scarlet Fever	1.9	0.97	0.22	0.07	0.17	0.16
Smallpox	0.92	0.04	....	....	....	....
Tuberculosis (All Forms)	128.2	74.5	56.0	53.0	51.3	48.9
Typhoid Fever	3.1	1.2	0.52	0.42	0.21	0.18

* Mean by 10 year periods. Estimated population for Jan. 1, 1925 and Jan. 1, 1935, July 1, 1940 and 1941 based upon Census Bureau figures; 1942 and 1943 from California Taxpayers' Association's estimates.
** Cases and deaths among military forces excluded.

Table 3.—*Case Fatality Rates for Certain Communicable Diseases**

Disease	1920	1925	1930	1935	1940	1941	1942	1943
Diphtheria	7.8	4.8	6.3	6.3	8.3	7.7	9.5	7.7
Measles	1.1	1.1	0.64	0.19	0.08	0.06	0.08	0.14
Pertussis	8.2	4.5	2.4	0.83	0.65	0.53	0.83	0.73
Scarlet Fever	2.2	1.1	0.97	0.60	0.26	0.09	0.23	0.18
Typhoid Fever	14.8	13.7	13.2	14.0	11.8	12.8	10.0	8.5

* Deaths per 100 cases.

has been a relative increase of cases in the older age groups.

DISEASES WHICH SHOW NO REDUCTION IN CASE RATES

In this class we might include such respiratory diseases as measles, pertussis, scarlet fever, meningitis, and poliomyelitis. While there has been no marked reduction in case rates of these diseases, there has been, in some cases, a gradual decrease in death rates. This is due to improved treatment methods. A striking example is meningitis. With the introduction of the sulfonamides, the case fatality rate has been reduced from over 50 per cent to approximately 15 per cent. Epidemic meningitis has shown a marked increase during the past two years. (See Table 1). It is likely that during the coming winter there will be a further increase.

The largest number of cases of measles ever reported in any year in California was reported in 1942. (Table 1). The rate for that year is more than three times as great as for any previous year. In spite of this great increase in cases there was the low death rate in 1942 of 1.4 per hundred thousand population. (Table 2). Evidence at hand indicates that some deaths from post measles, pneumonia and encephalitis were not properly charged on the death certificates.

Whether or not poliomyelitis should be classed as respiratory is moot, and no one will contend that control has been established. The epidemic of 1943 is second to that of 1934 in cases.

Case fatality rates in this disease have varied from 17.3 per cent for the epidemic of 1927 to 3.2 per cent for that of 1934. Rates for other epidemic years are 1930: 8.2 per cent; 1939: 7.9 per cent; and 1943: 6.0 per cent.

The 1943 epidemic has been characterized by a relatively high rural distribution, and by a sustained high incidence throughout the summer. For over three months the weekly incidence was over 100 cases, and rose as high as 175 cases during two separate weeks. No important evidence as to the method of the spread of the disease has been thus far adduced as a result of the 1943 epidemic.

INTESTINAL INFECTIONS

Typhoid fever (Table 1) and dysentery, as well as diarrhea of early childhood, have shown spectacular reductions. These diseases have been reduced largely through the sanitation of water, milk, and food supplies. The death rate of typhoid fever has dropped 97 per cent since 1915. Over a slightly longer period the same general statement might be made concerning the diarrheas of early childhood. Only a complete breakdown of community sanitation services, coupled with a general demoralization of our present social structure, is likely to reverse this picture.

TUBERCULOSIS

This disease has declined partly through the efforts of practitioners of medicine and health organizations, and partly because of better living conditions. The death rate of 48.9 for 1943 represents 3,809 civilian deaths. More persons in the age group of 15 to 40 die of tuberculosis than of any other condition. The death rate can be materially decreased.

Case finding programs by mass x-raying or tuberculin testing of positives are effective techniques, providing cases so disclosed are brought under effective treatment and control. The State Tuberculosis Association and several local tuberculosis associations have initiated programs for mass x-raying, utilizing modern equipment. Cases discovered in this way can be taken care of in beds which are available in many areas of the State. The private practitioner of medicine is potentially a most important factor in the further reduction of this disease.

As the incidence of tuberculosis decreases it becomes more imperative that individuals with sputum positive for tuberculosis be considered in the same category as individuals with smallpox or other acute infectious diseases, and that isolation be required and maintained for as long as the sputum is positive. Only by adherence to this principle can the disease be entirely eliminated.

VENEREAL DISEASES

The number of cases in the civilian population of early syphilis, reported by clinics and physicians in private practice, is increasing for the first time since 1938, the year following the establishment of the modern venereal disease control program in Calfiornia, and the first year for which these data are available.

From 1938 through 1942, the number of cases of primary and secondary syphilis annually reported decreased from 6,443 to 2,689. During 1943, 3,091 cases of primary and secondary syphilis were reported, as compared with 2,689 cases for 1942.

Examinations for syphilis, conducted by Selective Service, have succeeded in uncovering a large number of latent cases. This is reflected in the rise in total reported cases of syphilis from 21,733 in 1940 to 23,22 in 1942, which in turn has been exceeded during 1943 with 29,346 civilian cases reported.

Since gonorrhea is not as completely brought to the attention of physicians and is, therefore, not as completely reported, the picture in regard to a possible increase or decrease in the incidence is less clear than is true of syphilis. Reported cases of gonorrhea reached a peak of 19,638 in 1940 and dropped to 12,408 in 1942. During 1943, 14,632 cases were reported, as compared with 12,408 cases reported in 1942. This indicates a definite rise in this disease during recent months. There is evidence that the gonorrhea rate is being adversely affected by asymptomatic carriers.

The problem of control of syphilis among negroes, with their known greatly higher rate of infection, has been accentuated by the war. California's syphilis problem has been markedly increased by the migration of large numbers of negroes to this area, and control procedures must be directed toward this racial group.

More complete reporting by physicians of both syphilis and gonorrhea is needed to provide the community with accurate information on which to base control programs.

IN CONCLUSION

Meningococcic meningitis is likely to show an increase of cases during the coming winter, and should be given special consideration in areas of overcrowding.

Diphtheria is also likely to increase unless a sufficiently high per cent of immunes is built up. Diphtheria immunization and smallpox vaccination should be made projects of importance especially in the overcrowded defense areas.

The increased incidence of syphilis and gonorrhea is receiving a great deal of attention by organized health departments, and, to some extent, by private practitioners of medicine. Prompt diagnosis, effective teratment, and reporting of these conditions, are essential. Gonorrhea accounts for a good deal of lost time. Syphilis is cause for loss of time and also for loss of life.

The continued reduction of tuberculosis can only be expected if modern methods are introduced and carried out on a community basis. Team work between tuberculosis associations, private practitioners of medicine, and the health departments, is essential in this field.

Room 668, 760 Market Street.

DIPHTHERIA, SCARLET FEVER AND MEASLES: THEIR MANAGEMENT*

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DIPHTHERIA

THANKS to widespread immunization, diphtheria has become so rare that it tends to be forgotten. This relative freedom from what was once a scourge of childhood is due entirely to unremitting effort, particularly by health departments and pediatricians. Even greater zeal is needed now if this desirable status is to be maintained.

Active immunization is safe, simple, and highly effective with the use of toxin-antitoxin, fluid toxoid, or precipitated toxoid. Detailed discussion of these antigens is out of place here. Most workers favor one or the other toxoid; and better and more lasting immunity results from three injections than from one or two, usually at about one month intervals. When practicable, a Schick test should be done some months after the injections, and immunization repeated on positive reactors. All children should be immunized when about one year of age. Immunization may be done at 6 months of age; if it is not done by one year, it may be done at any later age. After the early school years there is increasing chance of reaction to the toxoids, and it may be safer to use toxin-antitoxin.

Passive immunization by means of a small dose of antitoxin was once a common practice for contacts. Its use should be limited to the rare occasions when contacts cannot be under medical supervision to insure prompt treatment of actual infection; otherwise serum reactions and sensitivity outweigh the prophylactic advantages.

Clinical characteristics vary somewhat with the location of the lesion. Nasal diphtheria may show no constitutional symptoms at all; merely obstructed nasal passages with irritating, sometimes bloody, discharge. Membrane in these cases may be so far within the nose as to escape casual examination. Pharyngeal infection produces the most marked toxicity, due to the greater absorptive power of that area. Fever is a regular finding, usually slight to moderate in degree; malaise is present, but at first is far short of prostration, frequently leading to neglect of the case; the throat shows at first the ordinary hyperemia and congestion of infection, shortly giving way to the characteristic dirty yellowish-white membrane which is most common in the tonsillar areas but frequently involves the pillars, uvula, and pharyngeal wall. These are the cases showing the cervical swelling of glands and edema of tissues in general, to which the term "bull neck" has been applied; fortunately such findings are rare in the early stages, and may be prevented by prompt diagnosis and treatment. Laryngeal involvement leads to stridor, sometimes so severe as to necessitate intubation or tarcheotomy to prevent strangulation, and to changes in the voice which may reach complete aphonia. Naturally these localizations of the lesion may occur in any combination as well as separately; also, infection may occur on other moist surfaces such as the eye, wounds, and the unhealed umbilicus of infants.

Diagnosis finally rests on one thing only, namely, the demonstration of the organism by culture or smear, or both. This is usually easy, and there are several techniques of rapid culture which entail very little delay. Occasionally, however, several attempts are needed before the bacilli are found; clinical suspicions should never be allayed by one negative culture.

Differential diagnosis includes a number of conditions causing lesions in the throat, and a few causing laryngeal changes. Among the former are streptococcic sore throat, which may produce a membrane indistinguishable from diphtheria, but which tends to be more acute and fulminant; Vincent's infection, in which the lesions are less symmetric in location and tend to involve the gums; infectious mononucleosis, with its longer history, tendency to general glandular enlargement, and characteristic blood picture and agglutination reaction; agranulocytosis with its striking blood picture; avitaminosis, usually suspected from the history; syphilis, which rarely presents the expected constitutional symptoms of diphtheria; and rarely other conditions, such as heavy metal poisoning. Spasmodic croup is the only laryngeal condition likely to cause confusion; it comes on at night, with striking abruptness, improves in the daytime, and does not cause loss of voice. In all these conditions, culture is the one indispensable in diagnosis.

Treatment centers around the one specific, antitoxin, which should be given at the earliest possible moment, even before laboratory proof of diagnosis if the clinical evidence is good, and in amounts adequate for cure without resort to a second dose. Dosage varies somewhat in different clinics, but the tendency is to give no less than 20 000 units, and to give two to four times that amount in neglected or fulminant cases. In early or mild cases the entire dose may be given intramuscularly; in other circumstances it may be desirable to give ten or twenty thousand units intravenously and the remainder intramuscularly. Appropriate tests for serum sensitivity should never be omitted.

Adjuvant therapy includes one essential which is often overlooked, namely, absolute flat bed rest, even in the mildest cases. This is of supreme importance in avoiding myocarditis, one of the most dangerous of all the complications of diphtheria. For the same reason copious intake of glucose, by vein if necessary, is indicated for the first ten days; if signs of myocardial failure appear (nausea, pallor, abdominal pain, marked change in pulse rate and blood pressure), glucose is forced and pitressin used in dosage such that the blood pressure is kept near the lower limit of normal for the age of the patient, as given in any textbook on diseases of children.

Moist warm air as in a steam tent relieves stridor, but intubation or tracheotomy may nevertheless be necessary. Pneumonia and other secondary infections may be treated in the usual way with chemotherapy.

Public health measures center around the isolation of patients, observation of contacts, detection of carriers, and active immunization of susceptible persons; of these, the last undoubtedly offers most toward the ultimate control of the disease.

SCARLET FEVER

Active immunization is possible by a series of injections of toxin derived from the streptococcus of Dick. The resulting immunity has been questioned on the ground that it may immunize only against the rash, and not against the sore throat and other symptoms caused by the streptococcus. In addition, reactions to the immunizing injections are rather frequent and troublesome, so that the procedure has never won widespread support.

Passive immunization may be effectively and safely accomplished with human convalescent serum, where it is available.

The best donors are those who have had scarlet fever within the preceding six months; from this interval to one year there is a considerable drop in the antibody content of the serum, but it is still quite effective. Appreciable amounts of antibody may be expected to persist indefinitely, but the titer becomes so low that very large doses are needed. Serum from a recent case should be effective in a dose of 10 to 20 c.c., or about twice as much whole blood may be used.

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* One of several papers in a symposium on "Communicable Diseases." Papers in the symposium have been collected by Dr. Edward B. Shaw, San Francisco.

Commercial antitoxin may also be used, with good results though with somewhat more chance of a reaction; and in addition, workers feel that certain protection can be given to contacts with small doses of sulfonamides. In general, however, the attack rate is so low that, if the patient can be isolated, nothing specific is done to protect the contacts.

Clinical characteristics when the disease is typical combine to make a very easy diagnosis; when it is not typical, as is often the case especially in mild attacks, the diagnosis may be difficult in the extreme and even be made only in retrospect after the appearance of the disease in a contact. The classic trio of fever, sore throat and vomiting may not all appear; vomiting not infrequently is absent, and the sore throat is quite commonly not mentioned by the patient, even though the appearance of the throat is suggestive or even typical. The throat tends to be fiery red, sometimes with follicular exudate or even frank membrane on the tonsils. This may suggest diphtheria or even actually be a concurrent diphtheritic infection. The tongue presents an appearance well described as strawberry or raspberry, especially about its margins; this finding may sometimes be obscured by coating on the tongue. The rash appears early, about 12 to 36 hours after the onset of symptoms. It appears first on the upper chest, and covers the entire body within a day, being heavier about the axillae, groins, and elbows. The rash is made up of fine punctate macules in contradistinction to the splotchy character of the rash in measles; tiny papules or vesicles may develop which give a "goose flesh" sensation when touched. It may be so faint as to be hard to detect, or it may be striking in appearance; it usually lasts two or more days, but it may be very fleeting or last some days longer. Desquamation appears early in the second week, usually proportional to the rash and varying from the bran-like flakes to casts of the fingers or toes. An enanthem is common in the early period of the disease, in the form of small, bright-red areas on the hard and soft palate, and occasionally the pharyngeal wall.

Diagnosis is entirely clinical, resting upon an evaluation of physical findings. The blood count shows a leucocytosis, but nothing typical. The Schultz-Charlton or blanching test cannot be used unless there is a fairly deep rash to attempt to blanch, and such a rash is usually typical enough not to need the test; in addition, rashes other than scarlet fever may show blanching. The inclusion bodies of Dohle occur in other diseases as well as scarlet; their absence might be construed as evidence against the diagnosis. Throat culture is of little value, as Dick's streptococcus cannot be differentiated from others by any ordinary laboratory procedure.

Differential diagnosis is most likely to involve the various toxic and allergic rashes, in which cases the history and the appearance of the throat and tongue may make the necessary distinction. Measles and rubella will seldom cause confusion.

Treatment is possibly most ideal with convalescent human serum when it is available; 60 to 100 c.c. by vein will usually remove both subjective and objective symptoms within 24 hours and reduce complications by three-fourths. Criteria for serum donors are the same as those suggested for passive immunization. Immunotransfusion brings similar satisfactory results. Commercial antitoxin is reported to be comparable to the human serum or blood, save for occasional serum reactions; I have had no experience with the present highly-purified product. Chemotherapy does not accomplish much if anything for the disease *per se,* but it does diminish streptococcal complication to about one-fourth the usual number. Sulfanilamide, sulfathiazole, or sulfadiazine may be given with approximately equal effectiveness. An approximate rule for treatment might be to give full dosage (¾ to 1 gr. per pound of body weight daily) for three days after the onset, two-thirds of this amount for three days, and one-third of the beginning dose for three days. One should never forget the many possible reactions of the sulfonamides.

Selected mild cases are often given no specific therapy whatever.

MEASLES

Measles is one of the most highly communicable of all common diseases; its distribution is universal, there is no means of active immunization, and there is no truly specific treatment. Thus both health officer and private physician are limited in their control of the disease to early diagnosis and isolation and symptomatic treatment. Epidemics in this locality have tended to recur in three-year cycles, but recently this periodicity has tended to disappear possibly because of immigration of susceptibles, and the disease may appear at unexpected times. In general, it tends to appear in widespread epidemics, usually in the spring, with only an occasional sporadic case at other times.

Clinical characteristics are referable chiefly to the respiratory system, plus a characteristic enanthem and exanthem. Symptoms begin abruptly with fever, usually rather high, and cough, rhinitis, and photophobia. The cough is persistent, severe, and hacking; the rhinitis and photophobia combine to produce a bleary expression of abject misery which suggests the diagnosis before anything definite appears to prove it. After about 12 hours of fever there may be a characteristic small, red spot at the inner canthus of the eye; on the second day about 95 per cent of cases will show Koplik's spots which are small, bright-red macules or papules in the center of which are tiny bluish white specks. Koplik's spots are most common within the cheeks opposite the molar teeth; they may be missed except with good sunlight. The rash tends to appear with great regularity on the fourth day, beginning on the face and extending over the rest of the body during the following two or three days. The rash is an irregularly crescentic, splotchy eruption which, in severe cases may become hemorrhagic. Having reached its maximum, the rash fades in about the same order as its appearance, the other symptoms disappearnig with it so that all are gone about ten days after the onset. Fever is usually maintained throughout, though there is a drop just prior to the appearance of rash, and a tendency for fever and rash to reach their high points together.

Laboratory findings are of little value. There may be a leucocytosis at the onset, but the white count is soon normal or decreased. Albuminuria is common, but nephritis is rare.

Differential diagnosis is seldom very difficult once the disease picture is complete. German measles is milder, has a shorter invasion period, little respiratory infection, and no Koplik's spots. Scarlet fever has a shorter invasion period, a smooth, rather than a splotchy rash, no general respiratory symptoms, Koplik's spots, or cough. Toxic rashes lack the history and constitutional symptoms of measles.

Treatment includes one procedure which in its way is a specific. Contacts may be given convalescent human serum early in the incubation period and protected from the disease; or it may be given late, in which case the disease occurs in modified form, but with production of good immunity. Serum antibodies of measles persist a long time, and although a recent convalescent is the ideal donor, the parents usually serve quite well. Dosage varies from 5 c.c. for infants to 12 or 15 c.c. for older children, when the serum is from a recent convalescent, or ¼ to ½ more when the parent is used. Whole blood serves equally well, but nearly twice as much should be given. A preparation of placental globulin is available which will yield comparable results, though with some tendency to reactions. Otherwise treatment is entirely symptomatic and supportive, except when complications occur.

Complications are most commonly those due to the streptococcus, such as otitis media and adenitis. Pneumonia also is common. These are well treated with chemotherapy.

Encephalitis is an uncommon but serious complication of measles, occurring in about one out of a thousand cases. It may occur at any time from the first symptom until well after apparent recovery, but usually about the time the rash fades. It has no proven treatment, but we have been impressed with apparent benefits of shock therapy. Activation of latent tuberculosis must also be expected.

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MENINGOCOCCUS DISEASE*

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WARTIME and similar conditions have invariably favored the prevalence of meningococcus disease. Present day conditions on the Pacific Coast, abnormal concentration of troups and of civilian workers, crowding and unsatisfactory housing, dubious hygienic conditions, may all be expected to provoke increased incidence of meningococcus disease. In at least some areas of this region increased prevalence may already be noted.

Before the advent of sulfonamides the end results of treatment, with specific antiserum, were dismally poor; but with modern chemotherapy, the infection is readily controlled if treatment is administered early and adequately. The outcome is so dependent on prompt detection and resourceful treatment as to constitute a distinct challenge to medical acuity.

This infection gains entry to the body through the upper air passages where it apparently multiplies and elaborates a specific toxin; thence it is carried through the blood stream to produce varying evidences of sepsis, and finally localizes in a serous surface, usually the meninges.

Primary infection in the nasopharynx is often asymptomatic and almost always escapes etiologic recognition. The succeeding stage of circulatory dissemination is sometimes equally insidious and evidenced only by the eventual localization of the organism. At other times, however, this septicemic stage causes symptoms of varying kind and intensity. In a few instances there is extreme infestation of the blood stream, and the patient rapidly develops signs of profound prostration and shock; there is frequently an accompanying hemorrhagic eruption, and within the course of a few hours meningeal localization occurs if the patient escapes an immediately fatal outcome. There are somewhat rare forms of infection, in which there is prolonged low-grade fever, hemorrhagic phenomena are usually lacking, and the diagnosis is established only by blood culture.

Hemorrhagic skin eruptions do not invariably accompany the septicemic stage, but when they do occur they are so characteristic as to be almost unfailingly diagnostic. In extremely fulminant cases purpuric spots are usually present, inasmuch as they proceed from the underlying cause of the profound symptoms—extensive damage of the vascular bed by the intense toxemia. Early meningitis constitutes a late stage of sepsis during which the existence of petechiae may indicate the nature of the pathogen. The eruption may be sparce or scattered, varying from a few petechiae to extensive areas of cutaneous hemorrhage, and may extend so rapidly that new spots may be observed to appear during the course of examination. Commonly, the lower extremities are more involved than the trunk or upper extremities, and petechiae are frequently found in the conjunctivae or upon the soft palate. Morbilliform, urticarial, or nondescript rashes may accompany the purpuric eruption. Emphasis should not be directed so much to the importance of the eruption as a diagnostic sign, as to the fact that, regarded together with other symptoms, it indicates the meningococcus as the etiologic agent, especially in cases in which delay for bacteriological confirmation may be extremely dangerous.

Meningeal localization produces the classical findings of purulent meningitis. The accession of symptoms is usually fairly abrupt, but may be more gradual and insidious. Fever and prostration are variable; pain in the neck, back and extremities, nausea, vomiting and headache are common symptoms. The patient will be found to have neck and back stiffness, which may be initially mild only to progress to extreme neck retraction and opisthotonos. There is accompanying spasm of the hamstrings, and either diminution or exaggeration of the tendon reflexes.

The intensity of symptomatology may vary considerably, occasionally the disease will be so florid as to make recognition easy, at other times symptoms may be deceptively mild. It is extremely important to note that young infants may proceed through a long course of infection with almost complete absence of characteristic signs, without the presence of bulging of the fontanel, neck-stiffness or retraction, Kernig sign, or high fever, to be clinically recognizable only in late stages of the disease when extensive damage has supervened.

LABORATORY FINDINGS

The diagnosis can frequently be established from clinical signs alone, but it is often necessary, and always desirable, to augment physical examination by appropriate laboratory studies, even if treatment is initiated in advance of this confirmation. The white blood count is usually, but not invariably, elevated in proportion to the fever, the chief increase being in the polymorphonuclear cells. In severe sepsis, the organisms may sometimes be identified in stained blood smears and are often readily detected in smears made from punctured petechiae. Blood cultures and spinal fluid cultures, in meningitis, are usually positive, although the meningococcus is somewhat fragile and growth may be obtained only with careful bacteriology. The spinal fluid may be cultured at the bedside upon ordinary Lodfler's slants (ordinarily employed for throat cultures) with very effective results.

The spinal fluid may be unmodified during the course of severe or even fatal sepsis, but as invasion of the meninges occurs the spinal fluid may successively show first only increased pressure, while, later there may be pleocytosis without the presence of organisms, and finally the fluid becomes purulent, and the organisms are readily identifiable by both stained smears and cultures. In the presence of meningitis the sugar content is diminished in the spinal fluid, this diminution being at once indicative of the nature of the inflammation, and roughly proportionate to the severity of the disease.

DIFFERENTIAL DIAGNOSIS

The septic stages of the disease must be differentiated from other forms of sepsis, in nearly all of which skin manifestations are much less common and do not reproduce the purpuric nature of meningococcemia. Septicemic invasion by staphylococci and streptococci will furthermore usually be more clearly associated with an obvious initial focus of invasion.

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* One of several papers in a symposium on "Communicable Diseases." Papers in the symposium have been collected by Dr. Edward B. Shaw, San Francisco.

Other forms of meningeal invasion are sometimes differentiated from meningococcus infection with difficulty. Most forms of purulent meningitis will usually reveal the causative organism in great profusion in stained smears or in culture, whereas the meningococcus is somewhat more difficult to demonstrate. Other central nervous system infections will occasionally lead to confusion. The various encephalitides usually produce only a slight increase in the spinal fluid cell count. Poliomyelitis produces a clinical picture of neck and back stiffness, hamstring spasm, soreness and tenderness in the extremities, very slight increase in the white blood count, and increase of spinal-fluid cell count to, usually, only two or three hundred, rarely to as much as one thousand. The meningo-encephalitis, which follows mumps, is usually identified by the antecedent infection and is characterized by only a moderate increase of spinal fluid cells to 500 to 1,000, with marked lymphocytic predominance. Similar spinal fluid findings characterize the meningitides of virus etiology, including benign lymphocytic meningitis.

The content of reducing substance in the spinal fluid is of considerable importance in differentiating purulent meningitis from poliomyelitis, encephalitis, and the virus meningitides; in these latter conditions spinal fluid sugar will be normal or slightly increased, and it is almost invariably decreased in all forms of purulent meningitis. The blood sedimentation rate is increased in purulent meningitis, normal in virus infection of the meninges.

The diagnosis is established by a summation of the clinical findings, those indicative of sepsis and those pointing to meningeal inflammation. It is frequently essential to proceed with therapy on clinical evidences alone. In any event, however, adequate bacteriological studies of the blood and spinal fluid should be *initiated* before the institution of specific therapy. This is particularly essential with respect to the exclusion of other forms of purulent meningitis which require much more intense and prolonged chemotherapy than does the meningococcus. One may commence treatment before the laboratory evidence is complete, but if adequate cultures are taken before treatment, bacteriological confirmation can usually be secured within the next 24 hours sufficeint to indicate the sort of treatment thereafter desirable.

TREATMENT

The meningococcus is so extremely sensitive to the sulfonamides that this form of treatment has almost entirely supplanted any other. The infection will usually be controlled by relatively small doses of the sulfonamides. Almost anyone of those commonly employed will be effective: sulfanilamide, sulfapyradine, sulfathiazole and sulfadiazine. The use of sulfathiazole is frequently objected to upon the grounds that the drug does not penetrate the spinal fluid. This objection is not altogether valid, because obviously the desired result is penetration, not of the spinal fluid but of the infected tissues and the clinical results of treatment with sulfathiazole have seemed to be quite effective. The present drug of choice is sulfadiazine, although recent reports indicate that a new member of this series, sulfamerazine, is extremely effective.

The object of chemotherapy is to produce adequate blood stream concentration of the sulfonamide as quickly as possible. The patient should receive a dose of sulfadiazine which, for a small child, is slightly more than one grain per pound, and for an adult is slightly less than one grain per pound, usually not over 120 grains in 24 hours, except for extraordinary indications. The patient who is conscious and coöperative is given the entire daily dose orally within the first two to four hours of treatment. Thereafter, he is given one-sixth of this dose every four hours for two or three days, the dosage being gradually reduced and finally withdrawn in a period of seven to ten days. The patient who is unconscious and uncoöperative is given sodium sulfadiazine as a 5 per cent solution in distilled water, the initial dose being slightly more than one grain per pound for children, and somewhat less than this proportion and not exceeding 75 grains for an adult. Succeeding doses may consist of one-fourth the daily dose as the sodium salt intravenously given every six hours, resorting to oral dosage of one-sixth the daily dose every four hours whenever the patient is sufficiently coöperative. It seems to be advantageous to accompany the drug with sufficient oral dosage of sodium bicarbonate to maintain an alkaline urinary reaction. It is certainly essential that the urinary output be maintained by sufficient intake of fluid to carry out the crystalized drug. Many patients are seriously dehydrated at the height of the disease, and it is essential that before sulfonamides are initially administered, the patient be given sufficient fluid by mouth or by vein to safeguard adequate urinary excretion. For the first 48 hours the sulfadiazine blood level should be ten to fifteen milligrams per cent with a spinal fluid level of about 7.5 milligrams per cent. If these levels are not established, the dosage of the drug should be increased arbitrarily.

This method of treatment is almost astonishingly effective in the great majority of cases, and a successful therapeutic result will usually be attained even when the dosage employed is much less than optimum. Failure of treatment is commonly encountered only when the advance of symptoms is so rapid that the patient dies or is irreparably damaged before adequate levels of sulfonamide are established. The purpose of treatment should accordingly be to establish adequate blood levels quickly enough to arrest the progress of symptoms in advance of an extreme degree of damage. When an effective blood concentration of the drug has been achieved the patient will usually thereafter proceed to satisfactory recovery with a more cautious plan of chemotherapy. It is principally in those patients with fulminant sepsis that the rate of advance of symptoms is so rapid as not to be effectively controlled by chemotherapy alone, and this group of cases accounts for a large percentage of the mortality in any series, in which death occurs during the first 24 hours. These patients should be placed in a special category.

These malignant cases of fulminant sepsis must be promptly recognized as a medical emergency. The patient should be recognized upon clinical evidences and treated without delay for bacteriological confirmation, although blood cultures should be taken at the initiation of therapy for the sake of ultimate confirmation. A continuous venoclysis should immediately be established, and the patient be given 500 c.c. of 5 per cent dextrose in saline. The flow is then interrupted, and the patient given the usual intravenous dose of sodium sulfadiazine in distilled water. The venoclysis of dextrose in saline is again resumed, and into the stream of dextrose solution are introduced 20,000 to 100,000 units of meningococcus antitoxin. The amounts of sulfonamide, dextrose solution and serum are proportioned according to age, severity of infection, and degree of dehydration. Usually the severity of the disease is so great that precautionary testing for horse serum hypersensitiveness may be dispensed with, the existence of extreme degrees of hypersensitiveness is rare, although the serum may be introduced at first in minute amounts which is injected into the tube through which the dextrose solution is flowing and additional amounts successively injected as the venoclysis proceeds. The use of antitoxin intravenously introduces a slightly increased risk of treatment, and is applicable to only a small percentage of the patients treated, but it is the only method which will effectively reduce the 5 per cent to 10 per cent immediate mortality which occurs in fulminant cases of meningococcemia. The patient may be given intramuscular injections of adrenal-cortical extracts as a supportive measure.

When treatment has thus been instituted, it is thereafter carried on by means of the sulfonamide alone exactly as heretofore described.

SPINAL PUNCTURE

Spinal punctures are performed principally for the diagnosis of purulent meningitis, and many patients will not require additional spinal puncture for any purpose. Unless the hydrostatics of the subdural space are interferred with by repeated puncture, there will usually be no reason thus to relieve pressure, and subsequent punctures need only occasionally to be performed to confirm clinical improvement or recovery, or to determine the adequacy of spinal fluid sulfonamide levels. A majority of patients proceed so rapidly to evident clinical recovery that confirmatory spinal puncture is unnecessary.

PENICILLIN

Penicillin is demonstrably effective against the meningococcus and has been employed to a limited extent in the treatment of this disease. The response to sulfonamide drug is so satisfactory, however, that at a time when supplies of penicillin are limited, the use of this agent in meningococcus infection should be restricted to the occasional patient who is sensitive to the sulfonamides or the extremely rare instances in which the organism is refractory to sulfonamide treatment. Penicillin may be employed in dosage of 10-20 000 units, given intramuscularly every three hours. It is improbable, although apparently not definitely demonstrated, that the introduction of penicillin intrathecally is necessary or desirable as a routine of treatment of meningococcus disease. Unquestionably penicillin, in common with almost every other agent which may be introduced intraspinally, produces meningeal irritation and spinal fluid pleocytosis, which is confusing to the clinician and is therapeutically disadvantageous.

There is little doubt that at the present time the sulfonamide drugs are an almost completely adequate agent for the control of meningococcus disease.

PROPHYLAXIS

The communicability of endemic meningococcus disease is extremely low and contact cases are the exception. When there has been intimate contact within a family it is sometimes appropriate to safeguard contacts by the administration of sulfadiazine in doses of about one-half grain per pound per 24 hours for two or three days, which acts as an effective prophylactic. In the epidemic form of the disease in which bacteriological studies have revealed a high carrier rate in army camps or barracks, the use of similar dosage of sulfadiazine for 48 to 72 hours in the entire personnel will reduce the number and viability of organisms which are harbored, and this has been shown to be an effective measure in the arrest of epidemics.

384 Post Street.

No education, no refinements of civilization can compensate a people for the loss of their hardy virtues. The greatest danger of a luxurious civilization is that it is likely to lead a people to lose their fighting edge.—Theodore Roosevelt.

ACUTE ANTERIOR POLIOMYELITIS*

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MUCH attention has been focused on the problems of poliomyelitis by the controversy aroused following the introduction of the Kenny concept,[1] and, more recently, by the epidemic prevalence of the disease.

The etiological agent is a filterable virus which has been isolated from the nasopharyngeal secretions[2] and stools[3] of affected patients, as well as from the excreta of apparently healthy individuals. The virus may occur in sewage,[4] probably in contaminated milk, food and water, and may be passively carried by the housefly.[5]

The concept of entry through the olfactory end-plates has largely been discarded. Portals of entry may presumably be either through the gastroenteric tract[6] or the nasopharyngeal mucosa,[7] whence the virus is transmitted along autonomic nerve trunks to the central nervous system.

Dissemination of the virus within the central nervous system is widespread, but certain sites of predilection are most prominently involved. Many cells are damaged temporarily by the virus and later recover, but some are permanently destroyed in a spotty fashion. In those cases exhibiting flaccid paralysis, anterior horn cell destruction is marked. In numerous cases in which muscle spasm predominates lesions of the small internuncial neurones of the anterior horn have recently been described.[8]

CLINICAL OBSERVATIONS

In the light of recent observations, both the Kenny concept and the older orthodox concept appear to suffer from over-simplification. The relationship of the pathological physiology of the disease to the clinical picture is now in a state of revision.

Following exposure of a group of individuals to poliomyelitis several alternative courses may ensue. In most cases no infection will occur due to the presence of neutralizing antibodies. A smaller group of exposed individuals, after an incubation period of, most commonly, a week, but varying from four to eighteen days, will develop a systemic disease of no specific diagnostic features. Moderate fever, accompanied by nausea and vomiting, diarrhea or constipation, abdominal pain, or symptoms of infection of the upper respiratory tract, may occur. These symptoms, persisting for a few days, may constitute the entire illness, and the diagnosis may be only suspected clinically, unless the virus be isolated or a rise in neutralizing antibodies be demonstrated.

In a still smaller group of exposed persons the disease may progress to a point where it becomes clinically recognizable as involving the central nervous system. Evidences of nervous involvement may develop during the course of the prodromal illness described above, or may succeed it after an asymptomatic interval of several days. Rarely paralysis may occur abruptly without a disease of onset.

In a majority of persons in whom nervous system invasion is manifest, muscle spasm dominates the picture.[9] Although the pathogenesis of this phenomenon is the subject of debate,[8, 10, 11, 12] clinically it is quite striking, and may of itself be the cause of persistent disability. Spasm consists of hyperreactivity of muscles to stretch stimulation, and is manifested by limitation of motion of the part due to pain and contraction of the muscle. In every instance spasm of back muscles is present[9] and is characterized by rigidity of the spine and resistance to flexion. Patients commonly assume the "tripod" posture on sitting up. Spasm of the posterior cervical and hamstring muscles is almost as common. This stage or degree of involvement is commonly termed the "preparalytic stage," and the symptoms have usually been ascribed to meningeal irritation. However, it must be emphasized that not only does paralysis frequently not follow these manifestations, but also the signs may persist for months after all possibility of meningeal irritation is passed, and may indeed occur in the absence of spinal fluid pleocytosis.[9] Spasm may exist in any other muscles, although less commonly, including particularly the calf muscles, pectorals and muscles of the upper arm. The associated symptoms under these circumstances are: fever, usually of a moderate degree, although occasionally absent or very high, headache, nausea and vomiting, pains in the back and neck, and pains and sometimes paresthesias in the extremities. The patient is frequently drowsy when undisturbed, but irritable when examined.

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* One of several papers in a symposium on "Communicable Diseases." Papers in the symposium have been collected by Dr. Edward B. Shaw, San Francisco.

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In a smaller number of cases, appreciable muscle weakness is present in addition to spasm. Much debate exists at present over the cause of the muscle weakness seen in poliomyelitis.[8,10,11,12] Certainly at least some is due to anterior horn cell damage or destruction. In such cases the involvement may vary in type, location and degree. True flaccid paralysis of lower motor neurone type associated with atrophy, fibrillary twitching, and reaction of degeneration, may involve one muscle, or one or more extremities. In addition, frequently a weak muscle may exhibit a striking degree of spasm. Sister Kenny describes the condition of "mental alienation,"[1] wherein a muscle opposed to a muscle in spasm becomes weak or functionless. This she ascribes to absence of nervous impulses to the muscle without, however, any lesions of the nervous pathway. Whether this phenomenon alone can produce, if untreated, permanent weakness of a muscle, is open to question. On the other hand, clinically such a situation does seem to contribute to muscle weakness, but would appear to be due simply to the braking action of the opposing muscle and inhibition due to pain on stretching a muscle in spasm. It seems likely that weakness and flaccidity of a muscle cannot exist without at least temporary interference with its motor innervation on an organic basis, but that mental alienation may be coëxistent or superadded, and produce permanent disability if allowed to go untreated.

In addition to spasm and loss of function of muscles, incoördination of muscle action is often a cause of much disability. An involved muscle may contract[9,11] only in part of its belly, or from its origin, or most striking, the opponent of the muscle may contract. Frequently strong muscles are substituted for weak, producing a dysrhythmic motion.

The tendon reflexes, contrary to commonly-accepted precepts, are often normal or hyperactive when spasm is present in the effector muscle of the reflex arc.[9] Depressed reflexes are seen only in association with marked muscle weakness.

Involvement of the medulla usually occurs in combination with back and neck muscle spasm, or with more extensive cord involvement. Disturbance of the respiratory center is manifested by respirations which are irregular in depth and rhythm, although the patient is able to expand his chest fully, in contrast to respiratory difficulty due to spasm or weakness of the muscles of respiration. Paralysis of swallowing and phonation may be observed. Facial nerve lesions may be either peripheral or central in type. Deviation of the tongue may occur. Lesions of other cranial nerves are uncommon. Marked changes in sensorium are seen occasionally when the disease involves higher centers, and rarely ataxia and athetosis may signify cerebellar or basal ganglion involvement. Coma and convulsions are exceedingly rare.

Thus the clinical picture may consist of a wide variety of types and severity of muscle involvement. Mild spasm, involving the back and neck muscles, is frequently the entire extent of the disease. On the other hand any group of combinations of spasm and weakness or alienation may be present. Generally the maximum involvement occurs soon after the onset, but spasm or weakness may progress for as long as a week, especially if fever is present.

Poliomyelitis must be differentiated from: 1) other infections of the central nervous system, such as meningitis and encephalitis; 2) diseases producing muscle spasm or limitation of motion of parts, such as rheumatic fever and arthritis; and 3) from diseases producing a lower motor neurone type of muscle weakness, such as peripheral neuritis.

LABORATORY FINDINGS

Although a mild degree of leukocytosis is commonly observed, the examination of the cerebrospinal fluid is the only simple laboratory aid in the diagnosis. In most cases an increase in cells is noted. Early, polymorphonuclear leukocytes may predominate, but later lymphocytes are more numerous. The total cell count is generally less than 300 per cu. m.m., but occasionally as high as 1,000 cells or more may be present. An associated increase in globulin in about half the cases is the only other finding of note. The pressure is rarely greatly elevated. The sugar and chloride content of the fluid is characteristically normal, and this may be of aid in the differentiation from bacterial meningitis. In a significant number of clinically typical cases the spinal fluid may be normal on repeated examinations, and the diagnosis may only be made by continued observation of the patient.[9,10] Isolation of the virus from the nasopharyngeal washings or stools is not a practical procedure under ordinary circumstances. A rise in protective antibodies during the interval from onset to convalescence may allow a retrospective diagnosis in atypical cases.

TREATMENT

The Kenny treatment[1] appears to be the method of choice. The aims of the treatment are to eliminate muscle spasm, reeducate muscles whose function is disturbed, and to eliminate incoördinated use of muscles. Regardless of the origin of the muscle dysfunction observed in poliomyelitis, this treatment is entirely rational and, moreover, successful.

The patient is placed in a neutral supine position on a bed under whose mattress is a plywood board. A vertical footboard is inserted several inches beyond the foot of the mattress. Packs consisting of woolen material, cut to shape, and wrung twice out of boiling water are applied to all muscles in spasm. These are then covered with waterproofing and finally blanketing. Care is taken not to interfere with movement of joints. The foments are applied six times daily at the outset, but may later be reduced to four. The extreme degree of moist heat (approximately 170 F.) followed by rapid cooling has been found the most efficient means of relaxing spasm. Packs are continued until all muscle spasm has disappeared. When calf muscle spasm is alleviated, the feet are placed against the foot board to stimulate proprioceptive reflexes.

From the beginning, once or twice daily, the joints are put through whatever range of passive movement which can be encompassed without pain. As spasm subsides, reëducation of muscles begins. The patient is asked to concentrate on the insertion and movement of the muscle being reëducated and then the movement of the muscle is simulated passively. Later after several passive movements, the patient is allowed to attempt active contraction of the muscle. Great care is taken to prevent incoördination. This program is continued once or twice daily as long as required, since improvement may occur over a period of years. A thorough knowledge of muscle anatomy and function is necessary on the part of the physical therapeutist.

In patients exhibiting respiratory difficulty due to weakness or spasm of the muscles of respiration, frequent packing is the treatment of choice, but the respirator is occasionally necessary. If the respiratory center is involved sufficiently to cause hypoxia, the respirator is of definite, although limited value. Patients with pharyngeal paralysis do better with very frequent small feedings, but occasionally tube feeding is necessary, supplemented by parenteral fluids. Aspiration of secretions in the phraynx must be done frequently. Sulfonamides are of possible value in the prevention of pneumonia. Convalescent serum is of doubtful value. Prostigmine appears to relax the muscle spasm of poliomyelitis, but its exact place in the treatment is not clear.[9]

The prognosis in poliomyelitis is dependent on many factors. Cases exhibiting muscle spasm without appreciable weakness uniformly do well with the Kenny treatment, although they would probably recover, although more slowly, without it. Patients exhibiting muscle weakness may all be expected to recover function, at least in part, and without significant deformity. Bulbar cases have a 50 per cent fatality rate, almost always due to respiratory failure or its complications, but those who recover usually do so relatively rapidly and completely.

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Medical statesmanship comprises the art of changing the health condition of a community, county, or state from what it is to what it ought to be.—Walter F. Donaldson.

Life is short and art is long.

—Hippocrates, *Aphorisms*. No. 1. Hippocrates is speaking of the art of healing.

TROPICAL DISEASES*

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THE present world-wide conflict has suddenly revealed to the medical profession of the United States that tropical diseases no longer should be regarded a matter of text book consideration. The American troops are now serving in many foreign parts, with the majority in the tropics and in regions bordering on the tropics. The ever-increasing number of military and navy personnel returning to our shores with tropical infections, infrequently or rarely encountered in most of the sections of our country, presents a distinct challenge not only to the medical departments of the Army and Navy, but to the civilian practitioner.

It is apparent that this problem will not be limited to the duration of the war, but its many ramifications will, no doubt, cause increasing concern in years to come. The present trend of military operations indicates that, in all probability, certain detachments of American troops will be retained in the tropics for some time following the close of the war. Furthermore, it is not unlikely that many civilians representing governmental, industrial and educational agencies will carry on their activities in tropical and subtropical countries.

Following the return of the first groups of Army and Navy personnel sent home for the treatment of parasitic infections acquired in tropical combat zones, alarms were sounded warning that these men would serve as foci of widespread epidemics of catastrophic proportions. Speculations were rife as to what disastrous consequences would be produced by masses of disease-harboring troops dispersed throughout the nation. Time will determine whether or not we are justified in becoming unduly alarmed about these prospects. Natural barriers in addition to those created by our various public health agencies will continue to function just as they have in the past. The effectiveness of created barriers, however, is lessened due to the relaxed supervision existing under present war conditions.

Although there is little justification for the almost hysterical approach to the problem confronting us, it should be emphasized that there is inherent danger in the uncontrolled widespread dispersion, during the war and postwar period, of persons with active or latent tropical disease. Instances may be cited to show that new endemic foci can be established following the entrance of infected individuals into a community in which the disease in question had not previously existed. The introduction of malignant tertian malaria into Connecticut by members of the National Guard who had acquired infections in Southern camps during the Spanish-American War and the Aurora, Ohio, epidemic of 1934, which followed the importation of a single case of malaria, are examples worthy of notice. Of the several millions of men now enlisted in the armed forces the greater proportion are engaged in areas noted for the prevalence of some of the most terrible scourges of man: Africa, the Mediterranean littoral, the Middle East, India, China, and the islands of the Southwest Pacific. Our military operations in previous wars, with the exception of the Philippine campaign during the Spanish-American War, have been limited to the temperate regions, and the troops engaged were not subjected to the disease hazards which are ever

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present in the combat areas of today. It is apparent that with the movement of masses of troops into tropical regions and under conditions incident to the emergencies of war, some of these troops would become infected. Intimate contact with infected native populations is unavoidable, and adequate protection against arthropod and other intermediate hosts is not always possible. The increasing number of Army and Navy casualties being returned to the United States for rehabilitation clearly indicates the serious problem which has not at any previous time confronted the medical profession of our country.

It should be our immediate concern carefully to consider what effect the introduction of infected troops will have on the civilian population of this country. Whether or not new endemic foci will arise is, of course, still problematical. It is not beyond the realm of possibility, considering instances in the past, that certain disease-producing agents will find suitable conditions for growth and multiplication in a new environment. Not only the actively sick, but those in the incubation or latent stages of disease are a source of potential danger. The modern rapid transportation of the sick by plane, or of individuals in the incubation period of their illness, are factors which tend to aid in the dissemination of disease throughout new localities. Planes as well as ships constantly arriving on our shores from the tropics not only transport the sick but may carry disease-transmitting agents. French corvettes transferred *Anopheles gambiae* from Dakar in Africa to Natal in Brazil, and the disastrous consequences which followed during the thirties are known to all. Energetic suppressive and control measures finally eliminated this dangerous mosquito from Brazil. Constant vigilance averted a recurrence of a similar situation when in 1943 it was discovered that live *A. gambiae* had been found in planes coming from Accra and Dakar in Africa to Natal. The spectre of another era of high death rates and untold suffering loomed up when five live *A. gambiae* were caught in homes near the Natal airport.

Many of the more important tropical infections—malaria, trypanosomiasis, leishmaniasis, filariasis, schistosomiasis—are diseases which tend to produce a chronic stage of long duration. If individuals infected with any one of these diseases migrate to new areas they will serve as nuclei of infection over long periods of time, and ultimately prove to be the original source of endemic foci. Furthermore, if this group of diseases conferred a lasting immunity, the individual who had suffered an attack would be eliminated as a potential source of infection, but unfortunately the protection afforded is only transient. It is not unlikely that physicians will be called upon in the near future to diagnose and treat certain diseases of tropical origin. Many will be confronted with conditions with which they have had no previous experience. Complications will arise when infections commonly met with in our country are superimposed upon those acquired in the tropics. The problem is not of the future but is of immediate concern. Ever increasing numbers of Army and Navy personnel are now hospitalized in various parts of the country for treatment of diseases rarely or never encountered by the majority of the medical profession of the United States. Infections with the filarial nematode *Wuchereria bancrofti,* that causes elephantiasis and with the fluke *Paragonimus* that produces lung disease associated with hemoptysis, are two conditions which may be noted in this connection.

The various public health agencies, fully aware of the potential threat which our country faces at the present, are mobilizing their forces to prevent the importation of diseases from the tropics. They are exerting every effort not only to control the sick individual, but to eliminate him as a source of infection, and to erect barriers on our shores against the introduction of disease-transmitting agents. It is obvious that the physician will have an essential rôle in materially aiding these agencies in the control of tropical infections. He will be called upon to diagnose and treat imported diseases. Prompt recognition of these is imperative in order to facilitate isolation and control. Thus widespread dissemination of disease will be forestalled. In this discussion some of the tropical and subtropical protozoan, helminthic and virus diseases of timely interest will be considered.

MALARIA

Malaria and the dysenteries have incapacitated an alarming number of United States troops engaged in combat zones in foreign regions. The constant arrival on our shores of Army and Navy personnel suffering from malaria presents a problem not previously encountered by the medical and public health services. Individuals harboring the malaria organisms will be transported to all parts of this country. Many will be located in areas where efficient mosquito vectors are known to be present. Four important malaria-transmitting anophelines occur within the borders of the United States — *Anopheles freeborni, A. quadrimaculatus, A. pseudopunctipennis* and, *A. albimanus.*

If a number of infected individuals are concentrated in an area where an efficient vector is present an endemic focus may arise. Widespread outbreaks of malaria occur following the introduction of new species or even of a new strain of previously existing species into a nonimmune population. Malaria should be suspected in all persons living in endemic areas who develop fever, or in those who have been in endemic areas. Recurrences and relapses should be suspected in all patients with recent history of malaria. Under these circumstances malaria should be considered as a possibility, not only in those with chills and fever, but with any obscure febrile or nonfebrile illness. Strenuous activity, exposure, fatigue, shock, alcoholic indulgence or childbirth may precipitate serious consequences in persons who have had a previous attack, or in those under suppressive treatment. With such cases, where the parasite can not be demonstrated in blood films or under conditions where laboratory examinations can not be performed, treatment for malaria should be instituted immediately. Recent observations indicate that the predominant form of malaria found in men returning from the Southwest Pacific is the benign tertian type caused by *Plasmodium vivax*, and not the malignant tertian (subtertian) type caused by *Plasmodium falciparum.* This is somewhat surprising since *falciparum* malaria is thought to be the predominant form found in the tropics. Nevertheless, *falciparum* cases do occur, and with the establishment of ever-changing battle fronts in many parts of the world new areas will be penetrated and we may expect an increase in this severe tropical form. The practitioner in cooler climates, perhaps familiar with *Plasmodium vivax* malaria, does not fully appreciate the dangers associated with *Plasmodium falciparum* infections. The causative organism of tropical malaria produces an extremely high parasitemia which, in many instances, rapidly overwhelms the host. The high parasitemia which occurs, and grave consequences which follow infection with *Plasmodium falciparum,* may be attributed in part to the fact that the parasite attacks all forms of the red blood cells, and does not exhibit a preference for the immature red cells or reticulocytes as does

Plasmodium vivax. In addition, the parasite exerts a profound change in the physical characteristics of the infected cell. The parasitized red blood cells tend to adhere to the lining of the capillaries and to each other, ultimately producing emboli and thrombi in the brain and viscera. The rapid blood destruction resulting from the high parasitemia, and the plugging of the capillaries are mechanisms which, in part, cause the severe cerebral, gastric, choleraic, dysenteric or fatal afebrile algid types of *falciparum* malaria. Where there is a history of exposure to malaria and a febrile illness is present, associated with coma or shock, tropical malaria should be suspected. Fever, headache and prostration may be the only indications of cerebral malaria. Frequently there is no rise in temperature, and in comatose cases it may be normal or subnormal. Sunstroke, heat exhaustion, and acute alcoholism may mimic *falciparum* malaria. All of the characteristic symptomatology of acute appendicitis may be produced by an infection with this species. It is often difficult to arrive at a correct diagnosis of tropical malaria, particularly so, if the individual has been under suppressive treatment.

The diagnosis of malaria must be based on finding the parasites in blood films stained with Wright or Giemsa. The thick blood smear preparation is the one of choice. Previous to the war, the majority of laboratory technicians made little effort to learn the thick smear technique. The situation created by the present emergency has clearly indicated the advantages of the thick, over the thin smear method of examination. With the former procedure the concentration of the parasites permits a more rapid diagnosis, and the detection of higher percentage of positives. Everyone who is called upon to examine blood for malaria parasites should become familiar with this method. Thin smears should also be made and utilized when it is impossible to make a species diagnosis with the thick smear. In instances where parasites are not found, films should be made on successive days. During the initial attacks, although symptoms are present, the density of parasites may be very low, and with *falciparum* infections few parasites may be present in the peripheral circulation during the second twenty-four hours of each schizogenous cycle. It must be borne in mind that it is often difficult to demonstrate parasites even in patients who have cerebral involvement or who are comatose. For the management of malaria it is essential that a species diagnosis be established, since the clinical approach and the method of treatment vary for each type of the disease.

In latent and chronic malaria the parasite density is often so low that parasites can not be detected by the usual laboratory procedures. For this reason, reliable serologic tests, if available, would aid in the establishment of a diagnosis. A satisfactory complement fixation test, employing an antigen prepared from the blood of monkeys infected with a simian parasite, *Plasmodium knowlesi*, has been developed. The reaction is highly specific for malaria, although the various types can not be distinguished. The present difficulty in obtaining antigen limits the adoption of the test as a routine diagnostic procedure. If an antigen prepared with the malaria parasite of chickens, *Plasmodium gallinaceum*, ultimately proves to be satisfactory for the complement fixation test it will, of course, be more readily available than one prepared with organisms from monkeys. Agglutination, precipitin and skin tests have been devised for malaria, but the technical difficulties involved and the restricted source of necessary amounts of antigens required for routine use, will prevent their adoption. Chemical tests, whose reactions depend on an altered ratio of serum proteins in malaria sera, have been advocated by some workers. Of these, the Wolff buffer precitation test is perhaps one of the easiest to perform, and may be of aid in establishing a diagnosis particularly in latent and chronic malaria.

The overwhelming number of cases of malaria in our troops overseas has made it mandatory that more effective methods of drug control of the disease be found. Although atabrine and quinine, the two drugs most commonly employed, have been known for some years, it is unfortunate that there is still so much controversy with respect to their use. At present neither of these drugs, nor in fact any drug known, will prevent mosquito-borne infection with human malaria. Furthermore, complete sterilization of an infection, with consequent prevention of relapses, cannot be achieved. Frequently the clinical manifestations of the disease cannot be suppressed. The lack of an efficient chemotherapeutic agent for the management of malaria has occasioned an increasing number of controversial articles and observations on the merits and demerits of the drugs now in use. For obvious reasons large numbers of investigators are engaged in projects evaluating new antimalarial compounds or trying to determine methods and procedures which would permit a more effective use of drugs employed at the present. Much of the valuable information that has been obtained as the result of this work will have to remain as military information until the close of the war. In order to augment the dwindling supply of quinine, the American Board of Economic Warfare has advised the use of preparations containing the total alkaloids from cinchona bark imported from Central and South America. There is every reason to believe, in view of past trials in India and elsewhere, that the total alkaloids are just as effective as quinine. For the present, however, only antimalarial compounds available for general use are the two synthetic preparations—atabrine and plasmochin. Of these, atabrine is the present drug of choice for the treatment of an uncomplicated malaria infection. Atabrine, according to recent observations, is just as effective or even better than quinine for the treatment of clinical malaria as well as for suppressive use. The efficiency of these compounds depends to a great extent on the concentration of the drug attained in the blood plasma. However, quinine reaches a higher level within a shorter period than atabrine. For the treatment of uncomplicated malaria, the initial doses of atabrine should be relatively large so that a satisfactory level may be obtained. Smaller maintenance doses should follow.

There is a growing tendency to eliminate the routine use of plasmochin for the treatment of malaria. It produces severe toxic reactions and requires careful supervision on administration. When used alone it is not effective in the control of clinical attacks. Plasmochin cannot be used for suppressive treatment, since it has very little destructive action on schizonts. Although it does destroy gametocytes and consequently prevents the spread of the disease, it is questionable whether it will ever prove to be a practical method of control. Furthermore, experience has not supported the contention that when plasmochin is given after atabrine or along with quinine, the incidence of relapses is greatly reduced.

The severe problem now presented by malaria has necessitated a large number of research and clinical investigations. There is a pressing need to determine the most effective methods and plans of treatment. A wealth of experience has been gained at home and abroad both in the laboratory and in the field. It may be some time before a proper evaluation can be placed on the vast amount of information now accumulating relative to the most effective treatment régime for malaria. For obvious reasons some of this information will have to be withheld until the end of the war. When a physician, practicing in a nonmalarious area and possessing little or no experience with the disease, is suddenly called upon to handle an introduced case, he is at a loss as to what is the best treatment plan to follow. For this reason every physician should become familiar with the latest recommendations offered by Governmental or civilian agencies. Excellent advice on the drug treatment of clinical malaria may be obtained from Circular Letter 153[1,2] issued by the Office of the Surgeon General. This information and timely presentation should be in the hands of every practitioner for immediate reference. It is of interest to note in the Circular Letter that atabrine alone is advocated as the drug of choice for the most cases, and that the routine use of plasmochin is no longer advised. The dosages of atabrine and quinine which are now recommended are as follows:

1. Oral medication.

a. Atabrine hydrochloride 0.2 gram (3 grains) and sodium bicarbonate 1 gram (15 grains) by mouth with 200 to 300 cc. of water (or an equal amount of sweetened tea or fruit juice) every six hours for five doses, followed by 0.1 gram (1½ grains) three times a day after meals for six days (total 2.8 grams in seven days).

b. If atabrine is not available, use quinine alone, giving quinine sulfate 1 gram (15 grains) by mouth three times a day after meals for two days, followed by 0.6 gram (10 grains) three times a day after meals for five days (total 16 grams in seven days).

2. Parenteral medication

a. Atabrine dihydrochloride 0.2 gram (3 grains) in 5 cc. sterile distilled water injected intramuscularly with the usual precautions into each buttock (total 0.4 gram or 6 grains). If necessary, give one or two additional doses of 0.2 gram (3 grains) intramuscularly at intervals of six to eight hours. As soon as the patient can take and retain oral medication, give atabrine by mouth in such doses as to give a total by both routes together of 1.0 gram in forty-eight hours followed by 0.1 gram three times a day after meals for five days (total 2.8 grams in seven days).

(In emergencies, when atabrine and quinine for parenteral use are not available, quinine sulfate may be given by rectum, using a dose of 1 or 2 grams mixed with a starch paste, thin enough to run through a rectal catheter. This route should not be used more than once or twice.)

b. Quinine dihydrochloride 0.6 gram (10 grains) in sterile physiological saline 300 to 400 cc. (minimum 200 cc) injected intravenously with the usual precautions, especially avoiding speed. If necessary, do not hesitate to cut down to the vein. Repeat this treatment in six to eight hours, if the situation demands it. When the patient can take and retain oral medication, give a complete course of atabrine (preferable) or quinine by mouth as described for uncomplicated cases.

The Office of the Surgeon General recommends that with most cases the same plan of treatment be followed for relapses as for primary attacks. It is suggested that a continuance of maintenance doses of atabrine over a total period of two or three weeks be tried. With some cases repeated relapses occur, even though a regular course of atabrine therapy has been followed. For these, the Army recommends that quinine should be tried to prevent further relapses, provided the number of cases receiving treatment be limited. In this connection, in view of the present restrictions placed on the distribution of quinine, the use of totaquine U.S.P. XII (crude extract of cinchona alkaloids) may be worthy of trial.

The inherent dangers associated with a *falciparum* infection and the protean manifestations found in this type of malaria usually demand a more cautious approach on the part of the physician than if he were treating a *vivax* or quartan infection.

Most and Meleney,[3] in a recent paper, have already indicated, by means of pertinent case reports, the dangers and pitfalls encountered in the diagnosis and drug treatment of *falciparum* malaria. They recommend atabrine by mouth in all uncomplicated *falciparum* infections. In cases where blood smears reveal a severe parasitemia, or where there is visceral involvement, atabrine should be given intramuscularly or quinine intravenously. They stress the importance of starting such treatment early and continuing it with intensity until the clinical condition of the patient improves to the point where oral medication may be instituted. For the treatment of patients in coma, or in instances where cerebral involvement occurs, quinine dihydrochloride should be given intravenously every four hours with dextrose solution and isotonic solution of sodium chloride. Most and Meleney advocate spinal drainage for comatose patients, since this procedure may restore consciousness. They further suggest that the use of nicotinic acid intravenously is warranted, since there is evidence that it produces dilation of cerebral capillaries and increases cerebral blood flow.

AMOEBIASIS AND AMOEBIC DYSENTERY

Under combat conditions in the tropics it is not always possible to maintain rigid control of the various ways and means which favor the acquisition of an infection with *Endamoeba histolytica*. Infected native populations are an ever-present focus of the disease. During peacetime, about twenty-five per cent of service men returning from the Orient harbored the parasite. Whether or not particularly invasive strains of the organisms will be acquired is conjectural. Carefully conducted surveys have shown that about ten per cent of the general population of this country are infected with *E. histolytica*. That there will be a decided increase following the importation of large numbers of individuals harboring the amoebae is problematical. An increase in the morbidity rate will be in direct proportion to the sanitary and hygienic level of the communities to which these individuals are transported.

Of the various clinical variations caused by *E. histolytica* acute amoebic dysentery is the least difficult to diagnose. The chronic types may persist for years without recognition. The potential danger of this protozoan infection is not so much the production of large numbers of cases of acute dysentery, but the serious complications which may terminate an infection of long duration. Amoebic hepatitis, abscess of the liver, and rarely abscess of the lung or other organs are dangerous involvements. These are frequently difficult to diagnose. The diagnosis of amoebiasis and amoebic dysentery rests solely on the demonstration of *E. histolytica*. The laboratory diagnosis should be performed only by those who are familiar with the morphology of the protozoa of the human intestinal tract. A careful selection and handling of clinical specimens and the employment of suitable concentration and staining procedures will facilitate the recovery of the organism.

Carbarsone, vioform and emetine hydrochloride are the drugs of choice for the treatment of amoebic infections. Clinical cure and eradication of the infection may be accomplished if these are judiciously employed. However, effective results are obtained only if the limitations of each of these are recognized. The clinical type of the disease present will determine the choice of drug or drugs. Many favor the use of two or three of these drugs in combination for the management of an infection with *E. histolytica*.

For the treatment of acute malignant amoebic dysentery rectal administration of carbarsone is recommended. A retention enema is given at night (carbarsone 2 grams dissolved in 200 c.c. of a 2 per cent sodium bicarbonate solution) following a cleansing enema of 2 per cent sodium bicarbonate solution. A mild sedative may aid retention. The treatment is continued until five enemas have been retained over night . This procedure should likewise be followed for the less severe types of amoebic dysentery where there is a subacute onset and course. Vioform is too irritating and should not be given by rectum. As soon as the symptoms are controlled, oral administration of either carbarsone or vioform should be instituted, as described later for chronic amoebiasis. The routine clinical use of emetine for the treatment of amoebiasis or amoebic dysentery is not advised because of its direct toxic action. Although it has doubtful curative powers it is of definite value in controlling acute symptoms. Where the use of this drug is indicated, intramuscular injections of emetine hydrochloride 0.03 gram (½ grain) twice a day or 0.06 gram (1 grain) once a day for four to six days are given. As soon as the acute symptoms have subsided the injections of emetine should be stopped.

For the treatment of chronic amoebiasis, or of so-called "carriers," carbarsone or vioform are recommended. Carbarsone 0.25 gram (4 grains) is given by mouth three times a day for seven days. The course may be repeated following an interval of ten days, if amoebae reappear in the stools. Vioform 0.25 gram (4 grains) may be given three times a day for ten days. If necessary additional courses of vioform may be given with intervals of at least ten days. In cases where amoebae persist in the stools in spite of treatment with either of the two drugs, alternating courses of carbarsone and vioform may be tried. With frank amoebic hepatitis and with liver abscess emetine hydrochloride is the drug of choice. It is the only available agent which has proved satisfactory for the treatment of these conditions. The drug is administered as described above, but injections are continued for eight days, and these are then followed by a course of carbarsone or vioform by mouth.

LEISHMANIASIS

The leishmaniases are widely distributed diseases endemic in regions where many of our troops are located. Kala-azar, a visceral form, occurs in the countries bordering the Mediterranean, South Russia, India, China, Manchuria, Abyssinia, Sudan and certain sections of South America. It produces an irregular recurring fever over a period of weeks, progressive enlargement of the spleen, later of the liver, emaciation, anemia, leukopenia and often dysentery or diarrhea. Oriental sore, a cutaneous form, usually is not present in regions where kala-azar is found. It occurs in Mediterranean countries, Central Asia, India, China, Middle East, many parts of Africa, southern Russia and in northern Australia. Espundia or nasopharyngeal leishmaniasis is found only in South and Central America.

The exact mode of transmission has not been demonstrated for all the species of *Leishmania*, but in all probability flies belonging to the genus *Phlebotomus* are the vectors concerned. Recently kala-azar and oriental sore have been transmitted to human volunteers who submitted to bites of infected *Phlebotomus*. These flies are so minute they can readily pass through an ordinary mosquito net. Since their breeding places are rarely found, they are difficult to control.

Only a few imported cases have been detected in this country. The writer secured cultures of *Leishmania donovani* from postmortem spleen tissue obtained from a United States soldier who had returned from China. A recent report indicates that 499 cases of cutaneous leishmaniasis have occurred in American forces in the Middle East. Newly-arrived immigrants are most readily attacked. There is little known about the species of *Phlebotomus* which occur in the United States. Very few have been described. The appropriately named sandfly, *Phlebotomus diabolicus*, first discovered at Uvalde, Texas, is an avid feeder on man.

The specific diagnosis of the visceral type of leishmaniasis depends on the demonstration of *Leishmania donovani* in smears or cultures of specimens obtained by sternal or splenic puncture. The organisms may also be demonstrated in smears or cultures of peripheral blood. With the cutaneous and nasopharyngeal types, specimens for examination are obtained by aspirating material from the indurated zone surrounding the ulcers on the skin or from nodules or ulcerations in the mucous membranes.

Various antimony preparations have been widely employed in the treatment of the leishmaniases. Of these, sodium or potassium antimony tartrate have been in use for a number of years, but more recently certain pentavalent antimony compounds have been developed which are less toxic, and in all proability more effective than the tartrates. Neostibosan is the least toxic and most effective drug of the pentavalent group. It has the advantage that it may be administered intramuscularly. Furthermore it is of particular value in the treatment of kala-azar in children. The type of leishmaniasis which is present in the Egyptian Sudan does not respond to treatment with antimony preparation. Recent investigations have shown that certain aromatic diamidines are effective chemotherapeutic agents for this resistant type of infection. Oriental sore responds very favorably to intramuscular injections of fuadin, a trivalent antimonial, or to intramuscular injections of neostibosan. A solution of berberine sulphate injected into the edges of the sores, or the topical application of dry ice have been recommended. Injections of a solution of atabrine in the skin around the ulcers, with concurrent administration of tablets of the same drug, have been recently suggested as an excellent method of treatment. With the American nasopharyngeal type of leishmaniasis, the treatment of the initial lesion is the same as that employed for Oriental sore. During the stage of the disease when the mucous membranes become involved, injections of tartar emetic or one of the pentavalent antimony preparations are employed, as recommended in the treatment of visceral leishmaniasis.

HELMINTHIC DISEASES

Serious problems have been presented to the Medical Departments of the Army and Navy by returning casualties, harboring helminths rarely encountered in our country. The practitioner, in all proability, will be able to cope with hookworm, *Strongyloides*, *Ascaris* or tapeworm infections, but some of the unfamiliar types will cause difficulties in diagnosis and treatment. The threat of widespread dissemination of helminths during the war and postwar period cannot approach that offered by the protozoa. The complicated life cycles, the dependence on specific vectors for transfer, the limited geographical distribution and the inability of the parasite to multiply in the human host are factors which tend to limit the dispersion of many types of metazoan parasites of man. The laboratory diagnosis of helminthic diseases has been greatly facilitated during recent years, following the introduction of more specific and refined techniques.

Numerous cases of filariasis have occurred in the armed forces stationed in the Southwestern Pacific area. The return of troops exhibiting the early symptoms of this disease has created an exigency not encountered in previous wars. The thread-like filarial worms which cause this condition are widely distributed throughout tropical regions of the world. The species associated with filarial lymphangitis and elephantiasis are *Wuchereria bancrofti* and *Wuchereria malayi*. Two distinct forms of *W. bancrofti* occur. The one found in the Philippines, Samoa, Fiji and other Pacific Islands produces microfilariae which may be detected in the peripheral blood in equal numbers by night and day. The other, which occurs in North Africa, West Indies, South America and China, gives birth to microfilariae exhibiting nocturnal periodicity—i.e., in peripheral blood in larger numbers at night than day. *Wuchereria malayi* is widely distributed in rural sections of Malaya, the Dutch East Indies, Central India, Ceylon, South China and Indo-China. The microfilariae of this species likewise exhibit nocturnal periodicity. Numerous mosquitoes—*Aedes, Anopheles, Culex, Mansonia*—transmit the infection. Our native mosquitoes may become infected if little effort is made to control imported cases of filariasis. Charleston, South Carolina, was formerly an endemic focus of infection for *W. bancrofti*.

The early symptoms of the disease have appeared in military personnel who have been in endemic areas for a period of only two or three months. Early in the disease a recurrent lymphadenitis followed by lymphangitis occurs with fever usually present. Later, elephantiasis of the scrotum, legs and arms, hydrocele, lymphatic varicocele, epididymitis and chyluria may appear. A period of one or two years may elapse following inoculation before the blood becomes microfilaria positive. It must be borne in mind that microfilariae may be found in subjects exhibiting no clinical symptoms of filariasis. In all probability very few, if any, of the service men returned to this country will develop the elephantoid deformities associated with filariasis. In regions where there is a high incidence of infection among native populations a very small number, probably less than 1 per cent, of those harboring the filariae develop severe manifestations of the disease. A large scrotum or an elephantoid leg follows repeated heavy infections obtained over a number of years.

The specific diagnosis depends on the demonstration of microfilariae in thick blood smears. In regions where the larvae exhibit nocturnal periodicity smears should be prepared from blood obtained at night. In the early stages of filariasis where microfilariae cannot be demonstrated, an intradermal test and a complement fixation test may aid in establishing the diagnosis. An extract of the dog heartworm, *Dirofilaria immitis*, is the antigen employed for these. There is no established specific treatment for *Wuchereria* infections.

VIRUS DISEASES

The diseases of virus origin, usually associated with warm climates, causing the most concern at the present are dengue, dengue-like fevers and yellow fever. All of these have epidemic potentialities. Dengue and a clinically related infection, sandfly fever, have interferred with the effectiveness of military operations in the Pacific and Mediterranean areas. Dengue is not a stranger in our country. About 30,000 cases occurred in Galveston, Texas, during the summer and fall of 1922. A serious outbreak originated in Miami in 1934, spread to Jacksonville and then to Georgia. The epidemiology of dengue is strikingly similar to yellow fever. The yellow fever mosquitoes, *Aedes aegypti*, and *Aedes albopictus* transmit the virus. The introduction of infected cases into a community where there are many susceptible individuals and numerous *Aedes aegypti* may lead to an epidemic of dengue which may last for several years. The outbreaks which occurred in the southern part of the United States indicate the prevalence of *Aedes aegypti* in that region.

The disease is characterized by sudden onset, fever with "saddle back" curve, muscular pains, intense post-ocular pain and a scarlet fever or measles-like rash beginning on hands and feet and spreading to other parts. Prostration occurs in a few hours. Repeated attacks are common. There are no effective immunization procedures. Treatment is symptomatic. The most satisfactory method of control for dengue is based on measures directed against *Aedes aegypti*.

There are several diseases which clinically resemble dengue, but are of shorter duration and usually do not have a recurring fever or rash. The most important of these is sandfly fever (Papataci fever, Phlebotomus fever, three-day fever) prevalent in the Mediterranean area, Middle East India, China, East Africa and northern Argentina. The virus is transmitted by various species of sandflies. In the Mediterranean region *Phlebotomus papatasii* is the principal vector. There is no specific diagnosis or treatment. Preventive measures are directed against the sandfly.

The threat of yellow fever is apparent to all. This disease, more than any other, has occasioned the rigid quarantine regulations instituted to prevent the importation of infected persons and virus-bearing mosquitoes into our country by airplane transportation. The availability of an effective vaccine conferring an immunity of several years duration will, in all probability, remove the danger attendant with the introduction of nonimmune troops into endemic areas. Opportunities for the introduction of cases of yellow fever or of infected mosquitoes are greatly increased under wartime conditions. Although the armed forces may be adequately protected the vast majority of the general population is susceptible.

At the present there are extensive reservoirs of yellow fever in the jungle areas of tropical South America and Africa. The disease existing in South America exhibits epidemiologic characteristics which distinguish it from the classical *aegypti*-transmitted urban type found in cities and large towns. This form, endemic in Brazil, Ecuador, Bolivia, Columbia and elsewhere in South America, has been designated as jungle or endemic yellow fever. It occurs in forest regions and uncleared lands in the absence of *Aedes aegypti*. Other species of *Aedes* serve as vectors. Man is not the important reservoir of endemic yellow fever, but this rôle is assumed by monkeys, opossums, ant-eaters and other jungle animals. Epidemics may result if individuals, harboring the virus, migrate from jungle areas into urban or rural communities.

In the past, outbreaks of yellow fever have occurred in large cities on the Eastern Coast of the United States. Although it has not appeared in our country since 1905, the presence of *Aedes aegypti* and a susceptible population make it necessary to maintain constant vigilance. Although the warm sections of the Orient and Australia provide this same background, it is still an enigma why yellow fever has not become established in these regions. A provisional diagnosis of the disease is based on symptomatology. Specific confirmation that the virus present was yellow fever is established by a mouse-protection test.

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Desire not to live long, but to live well;
How long we live not years, but actions, tell.

—Rowland Watkyns, *Flamma sine Fumo: The Hour Glass.*

"FILTH" DISEASES*

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In the past the waging of wars has always been attended by an increase in the prevalence of diseases which follow the disregard of sanitary precautions against soil and water pollution. Food and water-borne diseases constituted one of the most important causes of epidemics among civilian and military personnels. The seeds for these epidemic diseases exist in all parts of the world, and experience has taught that, on several occasions during the past century, they have spread in epidemic or pandemic waves. As late as 1911, cholera reached the port of New York. The present day accelerated means of transportation has, in many respects, enhanced the risk, and has created a potential menace which cannot be disregarded. Only continuous vigilance will prevent the smuggling in of some of these infectious diseases which, for the present, are largely confined to their ancient endemic centers in Asia.

Aside from the dangers lurking from these outside sources, one is troubled with considerable anxiety by the lapses of community sanitation, which may provide for a rise in the incidence of food and water-borne diseases throughout the North American Continent. It may, therefore, be appropriate to briefly review the present-day knowledge, and offer suggestions concerning diagnosis, treatment and prophylaxis.

TYPHOID FEVER

A recent review on the incidence of typhoid fever in the large cities of the United States in 1942 (*J.A.M.A.*, 1943, 122:1181) indicates that this infection shows a progressive, favorable decline. The death rate from typhoid in 93 large cities fell from 0.50 per thousand in 1940 to 0.25 in 1942. Just as in Great Britain, so in the United States, typhoid fever has remained thus far a rather unimportant disease in the cities. However, in smaller rural settlements, and unorganized territories, the supervision, particularly of water supplies, is done carelessly and they are potentially unsafe. Uncooked salads, cheese prepared from raw milk, and raw seafood continue to offer hazards. Furthermore, the gigantic mass movements of workers to shipyards and factories doubtless bring carriers into regions in which these reservoirs of infection were rare. The physician must, therefore, remain typhoid-fever conscious, and remember that the course of the disease is frequently atypical, even abortive. Adequate laboratory facilities are available in even the most remote regions. Properly-collected blood specimens in special bile media, and stool samples preserved in the customary brilliant green-glycerine-solutions obtainable from the diagnostic laboratories, greatly facilitate the aetiological diagnosis. Today, no typhoid diagnosis is complete without the specific bacteriophage typing of the isolated strains. If, in any outbreak, bacilli of different "phage" types are isolated, then more than one source of infection can be presumed to exist. For example, outbreaks caused by contamination with sewage are often due to bacilli that belong to different "phage" types. It is thus of paramount importance that the infecting organism should be isolated in all clinical cases. *Widal or serum tests are merely supplementary*, and should not be employed. That a proven case of typhoid fever should be sufficiently segregated to prevent the infectious discharges from reaching other persons needs no emphasis. General medical and nursing care is the best treatment. If the patient stays at home and does not have full-time professional nursing care, it is important to teach the family the disinfection procedures. This service must be done by a public health nurse, who should assist in carrying out the physician's orders. Hospitalization is desirable both for the welfare of the patient, the protection of the family, and the community as a whole. Treatment with vaccines, serums and phages has been disappointing. Sulfonamide compounds are without therapeutic effect in typhoid fever, and in no instances have the faeces of carriers been cleared of the typhoid bacilli following long periods of drug therapy.

Immunization should be urged for all persons who are or may be in close association with typhoid cases or carriers. Institutional groups, as well as travelers to areas where the water and food supplies are unsafe, should also be protected. Ordinarily, *subcutaneous* injections of 0.5, 1.0 and 1.0 c.c. are given at weekly intervals; recent studies have shown that the *intracutaneous* injections of 0.1 c.c. are equally effective. *Immunization by the oral route is valueless.* Moreover, any procedure which tries to eliminate constitutional reactions reduces greatly, as a rule, the efficacy of the vaccine. Wherever the disease is prevalent and where conditions develop which may favor the spread of typhoid fever, it is advisable to encourage community immunization programs.

It is the duty of every physician to report immediately a suspected case of typhoid fever to the local or State Health Department in order that an epidemiological investigation may be promptly instituted.

SALMONELLA INFECTIONS

Information on the frequency of human infections with organisms of the paratyphoid group, nowadays called Salmonella, is very inadequate. In recent years it has become evident that the Salmonella types may cause any one of three clinical pictures: (1) The rather well-known enteric fever or Salmonella fever, which is similar to typhoid fever. (2) *Septic or purulent infections* resembling diseases caused by pyogenic cocci. (3) Gastroenteritis, frequently called "food poisoning." The most dangerous form of Salmonella infection is the *septic type*, which appears in sporadic cases but has a high mortality. Intestinal involvement is usually absent and thus the diagnostic difficulties are greatly increased. The blood invasion is evident from the high intermittent fever, the positive blood cultures, and from the localization of the infection in various tissues. Meningitis and osteomyelitis are not infrequent in children. It is important to emphasize that Salmonellas complicate nutritional deficiencies and other wasting diseases. *Salmonella fever* is usually milder and less typical than typhoid fever, with the exception of the cases caused by S. paratyphi A, B and C. Enlargement of the spleen may be absent, but abdominal pain may produce a pseudosurgical syndrome frequently leading to appendectomies. The *gastro-intestinal type* of Salmonella infection is rarely fatal, except in individuals who are weakened by other diseases or old age. As a rule, the incubation is not as short as in food poisoning due to chemical poisons or to the staphylococcic toxins. *One or two days* may elapse between the consumption of the contaminated food and the first symptoms of vomiting. In adults the diarrhea is less severe than in dysentery, while in children the choleriform character is quite alarming. The gastroenteritis of limited duration is largely conditioned by the effects of a poison rather than that of a bacterial invasion. However, this interpretation should not deter the physician from attempting an aetiologic diagnosis. The percentage of isolations of Salmonella from cases of "food poisoning" has greatly increased in recent years by improvements of the laboratory methods.

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* One of several papers in a symposium on "Communicable Diseases." Papers in the symposium have been collected by Dr. Edward B. Shaw, San Francisco.

From the George William Hooper Foundation, University of California, San Francisco.

Patients and chronic carriers are the reservoirs of the Salmonella fever infections. The infective agent is spread through contact, pollution of water or contamination of food. For most of the other Salmonella types, the primary hosts are animals and the vehicle is food. There is some evidence, however, that transitory human carriers may play a rôle. In a recent report on an institutional outbreak of S. typhi murium infection, apparently conveyed by turkey or its dressing at a Thanksgiving Day dinner, and involving 238 persons, it was noted that 41 of the patients still excreted the bacilli in the fourth week following infection. Over 5 per cent showed positive stool cultures in the seventh week. Such observations clearly impose on the physician and the Health Department great responsibility in preventing Salmonella infections from man to man. Wartime conditions, with continuous changing of kitchen help, waiters and waitresses, less training and growing lack of fastidiousness, scarcity of foodstuffs are bound to lead to the use of left-overs, and providing optimal conditions for food contamination by carriers. A glance at the reports which come in from Great Britain amply attests to the increasing dangers which might be anticipated.

The vast Salmonella reservoir which exists in the animal kingdom is fully recognized, but not always appreciated even by the medical and public health profession. The special liability of mice and rats has long been known, but many animal pathogens have also appeared in human infections. Thus, S. dublin (formerly known as S. enteritidis) from cows was proven responsible for several milk-borne or ice cream-borne outbreaks of acute gastro-enteritis. More recently Cherry, Scherago and Weaver report the finding of 5.2 per cent of retail meat samples with endogenous Salmonella infection of such types as S. typhi murium, S. derby, etc. The importance of birds as reservoirs of Salmonella strains, potentially and proven pathogenic for man, requires no emphasis; it is well to remember the infections traced to duck eggs, turkeys or pigeons (Monthly Bulletin of the Emergency Public Health Laboratory Service, September, 1943, Volume 2). In war time, there is an increased risk that shipments of hastily inspected, diseased and indiscriminatingly-purchased cattle and poultry are likely to be distributed, particularly through the "black market," so long as meat shortages continue to exist.

It is imperative, both from a clinical as well as a public health point of view, that the infecting organism should be isolated in all clinical cases. Strains obtained from infected persons or the causative food should be sent to an appropriate laboratory where typing of Salmonella cultures may be carried out (New York: Division of Bacteriology, the Jewish Hospital of Brooklyn, New York or Salmonella Center, Lexington, Kentucky). A serum or Widal test is frequently of little value in the diagnosis, since it is impossible to use all known Salmonella types as antigens. Experts in this field should be consulted; very few laboratories are equipped to handle the problems incident to these infections.

Serum treatment has not been tried extensively, but deserves further study. Sufficient evidence is not yet available to judge the clinical action of sulfonamide therapy. It appears that bacteremias are benefited, and *patients* harboring the S. cholera suis (a strain particularly susceptible to sulfathiazole and diazine) *should have the benefit of sulfonamide treatment.*

BACILLARY DYSENTERY

Epidemics of bacillary dysentery have always been the faithful companions of war, not only to the armies but to the civilian population as well. The magnitude of the problem may be judged from the experiences of the English army during the first World War; over 486 per 1,000 casualties in Mesopotamia were caused by dysentery. It remains an important war disease, and it has assumed in some of the theaters of war the position of Medical and Public Health Problem Number Two. Furthermore, it is well-known that, during the period when typhoid has continued to decline, the frequency of dysentery in the civil population has remained stationary; in fact, an appraisal of the situation by Felsen (*New York State J. Med.*, 1942, 42:789) would indicate approximately 700 000 cases of dysentery in the United States during 1933-1937. There is ample evidence that diarrhea and enteritis rank next to prematurity as cause of infant deaths (up to 14 per cent of all deaths under one year of age) under conditions of overcrowded living quarters and poor sanitation. Rural areas with primitive means of waste disposal have their autumnal visitations of dysentery, possibly associated with the prevalence of flies. In other regions the disease follows the rainy season, or the congregation of workers in plantations, schools, lumber camps and other establishments with inadequate sanitary facilities. Dysentery is a permanent infection in lunatic asylums and prisons.

The story how dysentery is spread has been greatly amplified in recent years. That *person to person transmissal of faecal pollution* is most important, and that *dysentery is "contagious"* has received overwhelming report through the careful investigations which have been conducted in this country and abroad. Due to improved methods of cultivation, it is now recognized that the *extent of carrierdom* within the population has been greatly underrated. At least 3 to 20 per cent of the recovered cases of dysentery remain carriers for 4 to 6 months. Recent data from New York, Georgia, New Mexico, Puerto Rico and Denmark leave no doubt that many individuals who had no history of diarrhea and no intestinal complaints were proven carriers. Thus, it is not surprising that soldiers on furlough may introduce dysentery cases to their families, or even cause outbreaks of dysentery.

Aside from direct contagion in which the contamination of latrine seats, or of the hands of nurses and attendants with infectious, sticky mucous faecal material is well proven, the indirect pollution of food and drink through the agency of house flies, which feed on dysenteric faeces, and then vomit or deposit the bacilli in their dejecta, accounts for a fair incidence of dysentery disease. Several large milk-borne Flexner dysentery epidemics are on record.

The symptoms exhibited in bacillary dysentery depend to a large extent upon the type of Shigella bacilli involved. The main features of a typical attack are diarrhea, abdominal pain, fever, prostration and leucocytosis after an incubation time of from 1 to 6 days, about 48 hours being the average time elapsing between intake of the bacilli or food, and the sudden onset of diarrhea Everybody knows that, *whatever the causal organism* (Shiga, Flexner or Sonne Types), the infection may evoke symptoms covering a wide range of severity, and that a bacteriological examination of the contacts or members of a group or family will usually disclose mild and unsuspected cases. Since it is of utmost importance to diagnose the nature of intestinal disorder as early as possible with the view to prompt nad proper treatment, suitable specimens must be submitted for laboratory examination. *A physician who does not use the laboratory facilities in connection with the diagnosis dysenteric infections may be guilty of grave negligence.*

With the aid of the rectal swab technique (developed by A. Hardy: Public Health Reports, 1942, April 10, 57: No. 15), suitable specimens may be taken at any time. The swabs may be used immediately for plating on highly selective culture media such as the S. S. agar (Difco) or the desoxycholate-citrate agar, or they may be transported for any distance or held for several days provided the swab is moistened with glycerine-saline preservative (30 per cent glycerine in buffered saline), or coated with semisolid agar preparation (0.5 per cent agar in buffered saline). In acute cases, the microscopic examination of flakes of cellular mucous from stools collected in the bedpan, free from urine and antiseptic, is most useful. During the early stages of bacillary dysentery, the mucus is extremely rich in cells; about 90 per cent are polymorphonuclear leucocytes and 10 per cent are epithelial cells, mononuclears, some macrophages and eosinophiles. Cultures from semi-formed stools or brownish faecal discharges are useless.

The serodiagnosis with the patient's serum has little value. In chronic cases *sigmoidoscopy* is invaluable, since it furnishes information relative to the appearance of the bowel, suggests the nature of the infection and, through the swabbing of the ulcers, furnishes ideal material for cultures, the type of exudate and the demonstration of Entamoeba histolytica in amoebiasis.

The *treatment* of dysentery has been revolutionized through the introduction of *sulfa drug therapy.* Recent observations indicate that *sulfadiazine* should be the first choice rather than sulfaguanidine, at least in the treatment of S. flexneri, S. sonnei and S. newcastle. An initial dose of 3 grams (45 grains), then 1 gram (15 grains) every 4 hours night and day, usually bring improvement in 3 days or sooner. The dose may then be reduced to 1 gram 3 times daily; this treatment is continued until stools have been normal for 4 days. In tropical climate, sulfaguanadine (initial dose 6 grams and then 3.5 grams every four hours) is to be given preference. An adequate fluid intake must be maintained. To prevent collapse and acidosis, 5 per cent dextrose in normal salt solution with sodium carbonate, thiamin hydrochloride, ascorbic acid and nicotinic acid should be used. Plasma should never be given until dehydration has been completely relieved. Serum treatment alone in the light of newer knowledge is of doubtful value. *Patients should not be discharged from supervision without proven negative stool cultures for dysentery bacilli.* Strict isolation of dysentery cases in special wards and utmost care in the handling of bedpans and secretions are imperative. Nurses and attendants must wear rubber gloves for protection.

Prophylactic vaccination either by the subcutaneous or oral route is not warranted by the evidence at hand. It need hardly be emphasized that sanitation is the backbone of the control measures against dysentery. Many communities, particularly in the rural areas, are still negligent in their disposal of human waste. Little effort has been or will be made to limit fly-breeding, or to decrease contamination by flies, as the war progresses. Dysentery still costs thousands of lives, incapacitates other thousands for a life time, and is a major factor in temporary disablement with all its consequences on the morale of the people. The dysentery problem dismissed by the inadequately informed physician, with the vague and meaningless diagnostic term "summer diarrhea" or "intestinal flu," requires energetic action both by the medical profession and the public health agency of a community. The time may not be far off when the systematic culturing of population groups in search for carriers and their treatment with sulfa drugs will become an important protective measure. The laboratory tools and therapeutic agents are available; why not use them!!

FOOD POISONING

(a) *Staphylococcal Food Poisoning:*

Even a casual perusal of the daily press furnishes such headlines: "47 workers stricken by food poisoning"; "4, made sick by tainted food, recovering." Certain lapses in community or, more specifically, in kitchen and cafeteria sanitation are constantly taking place. Indeed, the margin of security against food intoxication and infection is strained to the danger point. As wartime conditions progress to engulf the continent, the problem of food poisoning is likely to assume greater importance. The commonest and, unfortunately in some respects, the least controllable form is due to the staphylococci which produce enterotoxin. Its actual incidence is unknown, since only outbreaks involving fairly large groups of people are likely to be reported. The rather ubiquitous distribution of staphylococci, and the great variety of articles of food which may be polluted with these organisms through milk, fingers, droplets or flies make this form of food poisoning rather inevitable.

The symptoms are monotonously uniform. Within 45 minutes to 4 hours a feeling of nausea and severe abdominal cramps are followed by vomiting, which is severe and continues for hours at intervals of from 10 to 20 minutes. As many as 20 to 30 spells have been observed. Diarrhea, 1 to 7 liquid stools, beginning with vomiting or several hours after the onset, follows. Sensation of chilliness, pallor, cold sweats and profound prostration with rapid, occasionally thready-pulse, accompany the picture of shock. Muscular cramping, usually in the flexors of the legs, may be present. These acute symptoms may last for 1 to 10 hours; but, on account of the prostration, recovery may be delayed for from 1 to 2 days, to 1 week. In these instances a rise in temperature to 38.5° C. may be recorded. Despite the fact that the symptoms are sometimes very grave and alarming, the mortality rate from staphylococcus food poisoning is certainly very low.

The treatment must be primarily directed towards the relief of acute symptoms of shock. The patient should be kept warm and, if possible, put to bed. To relieve the pain, morphine may be required. In mass intoxications, the problem of adequate nursing of the desperately ill patients during the acute phase of the attack requires considerable ingenuity. In any event, the sufferer should not attempt or be permitted to walk, since minor exertion may lead to collapse. The symptoms of shock are due to loss of body fluids, and should be treated by giving salt solution parenterally.

The prevention of staphylococcic food poisoning offers many difficulties, since the public still believes that any food which smells and tastes normally is safe for eating. Many outbreaks are on record in which the laboratory examinations of the incriminated food yielded a powerful enterotoxin producing violent illness in volunteers, and yet the product had no abnormal odor or taste. Pasteurization reduces the hazard from endogenous staphylococcal infection of milk. On the other hand, exogenous contamination of food may be reduced by scrupulous sanitation in bakeries, sandwich counters, railway dining cars, and community feeding centers in war plants. It is absolutely *imperative* that the management of these important institutions inform the food handlers of educational propaganda campaigns concerning staphylococcal food poisoning and its prophylaxis. Health departments should insist upon refrigeration of all foods liable to this form of poisoning, require the reheating of custard-filled puffs, éclairs and cream layer pies, prohibit the display of pastries in shop windows, the holding of cream sauces and rapidly-cured hams on steam tables, etc. During summer months, the sale of pastries without adequate refrigeration should be restricted. The passing of ordinances is not enough; a campaign to educate all the less-enlightened, recently appointed food handlers, and the consuming public with regard to this form of food poisoning must be waged relentlessly.

(b) *Botulism:*

In anticipation that the preserving, particularly the home-canning of meats, and vegetables and fruits raised in the Victory Gardens will inevitably increase the incidence of botulism, i.e., home economics teachers and nutritionists in coöperation with the Health Department and the American Red Cross and other voluntary agencies have undertaken the instruction of the public at preventing these tragic deaths. Three principles are being stressed: (1) *Nonacid foods*, in particular such products as string beans, corn, asparagus, meats and fish, *must be processed in pressure cookers* in accordance with instructions outlined in the pamphlet on "Home Canning" by Hilda Faust (obtainable free from the Extension Service, College of Agriculture, University of California, Berkeley, California). (2) All nonacid home-canned foods should be *thoroughly boiled for at least 15 minutes before being served.* (3) Any product which emanates an abnormal odor suggestive of spoilage should be treated with lye and discarded; it should not be fed to chickens or hogs. Additional instructions aim at preventing elaboration of the toxin of Cl. botulinum by acidification, by curing with salt or by dehydration. Emphasis is placed on the well-known fact that the spores of Cl. botulinum may be found any time and anywhere in the soil, dirt, dust and grit adherent to vegetables and fruits. How effective this propaganda has been, the events during the coming winter months will disclose. During the first 8 months of 1943, the California State Department of Health records 7 cases of botulism, with 5 deaths. Such foods as tomatoes, mushrooms, figs and beet tops preserved by the water bath or cold pack method have been involved. In New Mexico canned pumpkin, and in Oregon asparagus have caused intoxications in 1943. Even if it be assumed that all cases of botulism have been reported, an annual average of between 8 to 15 outbreaks, and between 10 to 20 fatal cases, may be anticipated.

Physicians should remember that a botulinus intoxication may initially manifest itself in two forms, viz: (1) Sufferers with initial gastro-intestinal disturbance (nausea, vomiting and diarrhea) followed by typical botulism symptoms. (2) Patients in which typical botulism symptoms are first to present themselves. The earliest symptoms, which usually develop 12 to 36 hours after the ingestion of the spoiled poisonous food, are a peculiar lassitude and fatigue, associated with dizziness and headache, disturbances of vision, diplopia, difficulty in swallowing are the first signs of serious intoxications. The temperature is usually subnormal and the pulse, slow at first, becomes rapid (100 to 150 per minute). When a number of persons, who ate the same meal, complain of disturbances of vision, or when some patients remember having eaten food which tasted abnormal, or when, on a farm, the chickens are dying with "limber neck," the diagnosis is relatively easy. But when a single person is ill, the differential diagnosis between encephalitis, bulbar paralysis, methyl alcohol poisoning, or even mussel poisoning is difficult. The demonstration of the botulinus toxin in the blood of the patients, by injecting guinea pigs and mice with 1 to 2 c.c. of whole-blood or serum, may be valuable. Occasionally, the examination of the vomitus or stomach content may assist in the diagnosis. Remnants of the suspected food, when available, should always be examined for the specific toxin by an adequately equipped laboratory.

The prognosis in botulism is always grave, since the case fatality rate is exceedingly high, 60 to 80 per cent; in some outbreaks 100 per cent. Once the typical symptoms have appeared, the chances of recovery are very small, in spite of any treatment. Although no definite conclusions relative to the value of specific antitoxic therapy are as yet available, recent evidence suggests that the early administration of specific antiserum in *large doses*—50,000 units within the first 12 hours after the intoxication has been diagnosed—may save lives. The first administration should be made intravenously, and the serum diluted liberally in 5 to 15 per cent glucose solution (1 to 2 liters). Subsequent serum injections (50,000 units) may be made intramuscularly. The bivalent serum, which contains Type A and B antitoxin (5,000 units each), is available through the Lederle Laboratories, Inc. (San Francisco, 274 Brannan Street or Los Angeles, 643 South Olive Street), or Jen-Sal Laboratories, Inc. (1264 W. 2nd Street, Los Angeles, California). The Lederle antitoxin for humans, with 10,000 units Type A and B mixed, is sold at $9.60 per vial, while the Jen-Sal preparation, also Type A and B mixed, contains only 5,000 units and costs correspondingly less ($4.45 per vial). The patients must be tested for sensitiveness to horse serum before the injections are made. Members of a group who have participated at the same meal, although free from suggestive symptoms, and frequently denying the eating of the same food which is causing botulism in the participants of the dinner or luncheon party, should be given 2,500 units of the bivalent antitoxin. With the onset of visual disturbances, they should be treated intensively according to the scheme outlined above. The patients must be protected from fatigue and undue external stimulation. Feeding should be done with the help of a fine Levin tube through the nose. High soap enemas or solutions of the posterior pituitary may be tried to relieve the constipation. The sticky, ropy mucous that collects in the throat may best be relieved by aspiration.

Cases, or suspected cases of botulism, must be reported at once to the Departments of Public Health. A relentless educational campaign, teaching every consumer that nonacid foods, home-canned by boiling water or oven process *must be thoroughly boiled* before they are served, should ultimately reduce botulism to a very rare disease. Finally, physicians and health officials will find a great deal of valuable information in the recent Monograph on "Food Poisoning," by G. M. Dack (University of Chicago Press).

BRUCELLOSIS

Where Brucella infections are prevalent in the domesticated animals—cattle, hogs and goats—brucellosis, as a disease of man, may be encountered. Although not a filth disease in the true sense of the word, brucellosis is intimately related to a lack of food sanitation and proper herd management. Until pasteurization of milk or cream is universally and adequately enforced, or until the animal husbandman gradually eradicates Bang's disease from the dairy herd by vaccination instead of resorting to the expensive and ineffective system of segregating infected from noninfected cattle, the morbidity rate of human brucellosis from 3 to 6 per 100,000 in the United States will continue to be a plague for many an innocent person. In the dairy States, Brucella abortus is the chief cause of undulant fever, while in the hog raising States as, for example, Iowa, and the slaughter houses where swine are butchered, the chief source of infection is the Brucella suis. In the Southwest, contact infections, through the handling of afterbirth of goats infected with Br. melitensis, is responsible for seasonal brucellosis in herdsmen. Milk-borne infections with Br. melitensis are relatively rare. When cattle associate with hogs, they may become infected with Br. suis, which is more virulent than the bovine strain, and causes milk-borne outbreak of suis human brucellosis.

Since man is merely an accidental and probably an aberrant host for the Brucella organism, the severity of infection appears in a spectrum-like scale of gradations. Inapparent or subclinical infections are unquestionably common throughout the population. The epidemiological examination of occupational groups—packing-house employees, veterinarians, etc.—has amply proven that sometimes as many as 50 to 70 per cent of the individuals of a group had experienced an infection with Brucellas. With a few exceptions, these cases go unrecognized; but in some the infections, instead of being disposed of by the immunity mechanism of the individual, the microorganisms persist and may give rise to a chronic illness. The diagnosis of chronic brucellosis is exceedingly difficult, and requires the judicious, cautious and intelligent interpretation of laboratory tests. To stigmatize a patient with low-grade fever persisting for weeks and months, weakness, prolonged malaise and mental depression bordering on neurasthenia as brucellosis, because a positive skin test has been elicited, is frequently subject to serious doubts. Since chronic brucellosis develops in certain constitutional types with a labile nervous system, the mere intimation that he or she is the victim of chronic brucellosis greatly intensifies the invalidism of the patients. In proven chronicity of Brucella infection on account of its long duration, the care and treatment always offer many unsurmountable problems. Patients suffering from chronic brucellosis must be encouraged to work in order to avoid morbid introspection. Instead of subjecting them to all kinds of bizarre biological therapy, they should be so treated that their immunity mechanism becomes enhanced. Clinical experience suggests that this is accomplished by a combination of rest and regulated exercise, which promotes good physiological tone. Not infrequently, a change of environment to a high altitude has proven beneficial. Bed rest is essential only during extreme malaise and febrile periods. Liver injections may be useful. There is no specific treatment; in fact, the injection of vaccines or other bacterial preparations may do more harm than good. The consumption of milk or dairy products, which may contain Brucella proteins, should be avoided. Many of the symptoms of chronic brucellosis are attributable to a state of allergy, and consequently the intake or exposure to Brucella proteins is frequently responsible for the bout-like febrile recrudescences. The treatment of chronic brucellosis requires mature wisdom, judgment and individualization, and not irresponsible borderline quackery.

With the aid of such laboratory tests as blood cultures, agglutination and complement fixation tests, supplemented when necessary by the phagocytic or opsonocytophagic index test, the suspicion that a patient with fatigue, irritability, malaise, fever and chills, drenching night sweats, a temperature up to 103 or 105° F., loss of weight, secondary anemia, and essentially-negative physical findings over several weeks is a case of acute brucellosis is usually proven. Likewise, when localizations of the infection in the genital tract (prostatitis, epididymis) or gallbladder (cholecystitis) or meninges, and eyes or joints and bones (periarthritis, bursitis, spondylitis) make their appearance, the laboratory offers invaluable aids. Probably, in no disease is the coöperation between the clinical pathologist and the physician as important as in brucellosis. In the light of the available knowledge, it is imperative that no intracutaneous tests should be carried out before all the other tests have been carefully and repeatedly made by means of repeated blood cultures and serum tests. All skin test reagents stimulate agglutinins and complement fixing antibodies. Every physician should remember that the clinical significance of the intracutaneous "Brucellin" or "Abortin" test is comparable to that of the tuberculin test in the diagnosis of tuberculosis. A positive test merely denotes that the patient has been sensitized at some time by contact with the Brucella. Since the positive reaction persists for years, and possibly for a life time, the value of the reaction is decidedly limited. Many persons suffering from other diseases than brucellosis may give a positive "brucellin test."

The prognosis in brucellosis is favorable; at least in the United States the death rate is only about 1 per cent of the recognized cases. However, relapses are common in the cases with mild symptoms. Unfortunately, no specific treatment is known. One comforting fact, however, stands out regardless of the type of therapy: most patients, with very few exceptions, eventually recover. Proper symptomatic treatment makes the patient comfortable, and shortens the course of the disease. Convalescent human blood or lyzed vaccines (typhoid or Brucella) or other foreign protein as shock reagents may successfully be employed on intravenous injection. The prompt subsidence of symptoms in many cases certainly warrants the use of shock therapy, provided the patients have been properly prepared for this type of treatment. Experience has shown that patients with a leucopenia respond poorly to shock therapy. It is advisable to stimulate leukopoiesis by means of parenteral injection of liver extracts, forced and proper nutrition. Numerous drugs have been recommended and certain observers have lauded the sulfa drugs. There is suggestive evidence that acute cases of undulant fever with bacteremia may be cured when treated with sulfadiazine (one gram every 4 hours for 10 to 14 days). In combination with fever therapy, occasionally a subacute infection may be favorably terminated. It is not unlikely that chemotherapy is only effective when exacerbation with demonstrable bacteremia occur. Patients may respond to the first course of treatment, but rarely benefit from the second. The search for better treatment of brucellosis is just as important as the improvement of the diagnostic procedure, in order that the difficult problem in diagnosis, due to the variable clinical course of undulant fever, may be overcome. Until this goal has been achieved, the *prevention of brucellosis*, public health education of farmers and dairymen to the dangers from infected animals, both with respect to themselves as well as their livestock, and of the public in general to the danger of consuming raw milk and other unpasteurized dairy products, *remain paramount.*

U. C. Medical Center, Third and Parnassus.

TUBERCULOSIS IN WAR TIME*

Sidney J. Shipman, M. D.
San Francisco

One of the important diseases whose increase is feared as a result of the present world-wide conflict is, of course, tuberculosis. An examination of statistical data reaching almost to the beginning of the last century seems to indicate that tuberculosis has always increased during periods of hardship and war and that this period has been followed by a rather rapid decline. Possibly because infected individuals died more rapidly, the infection of others was therefore cut down temporarily as a result. Earlier statistics in tuberculosis, however, have been notoriously misleading because of inaccuracy in diagnosis.

During and shortly after World War I there was an almost universal rise in the tuberculosis death rate, followed by a fairly rapid decline which has continued in the United States until the present time. The influenza pandemic of 1918-1919, however, may have played a major part in influencing the trend during and after the war, and it is difficult to ascribe this peak solely to the effect of war unless one credits the war with the pandemic of influenza also. Fortunately for the United States, the tuberculosis death rate continues to decline even at present. The conditions which can make for an increase in the tuberculosis death rate are undoubtedly here, including longer working hours, crowded, unsanitary and otherwise unsatisfactory living conditions in many war production centers and a generally abnormal food supply, making difficult a perfectly satisfactory dietary régimé for those not adequately instructed. Nevertheless, perhaps due to the excellent and unremitting efforts of health departments, tuberculosis associations, medical men and social workers, these unfavorable factors have apparently failed to bring about a reversal of the long term down trend. It is true that complete data for the general population for 1942 are not yet available but preliminary figures tend to support this observation.

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* One of several papers in a symposium on "Communicable Diseases." Papers in the symposium have been collected by Dr. Edward B. Shaw, San Francisco.

One might expect the large increase of women employed in industry and the spread of colored workers throughout the country to exert an unfavorable influence upon the rate of infection and disease. Yet these groups also continue to show a decline in mortality. In contradistinction to the United States, the figures from abroad show that the expected increase there has taken place. Naturally, we have no reliable data for enemy countries but England's figures show a 10 per cent increase until recently, when there has been a little improvement. Even in America there are a few danger signals, however, which deserve attention. There appears to be some increase in tuberculosis morbidity among the early age groups and there is apparently some increase in military tuberculosis. These may be the first danger signals which point to a reversal.

The following factors are of great importance and should be appreciated by general physicians:

CASE FINDING

The widespread use of miniature films of 4 by 5 inches and 35 millimeters by the Army and Navy and Public Health Service, as well as by health departments and tuberculosis associations, has undoubtedly developed the most widespread and important case-finding program ever seen in the United States. The importance of these efforts lies in the fact that the incidence of re-infection tuberculosis in the presumably healthy adult male population is found to be between 1 and 1½ per cent. About half of these cases are found to be active and in need of treatment. This differentiation, however, must be met by the family physician after the case has been discovered.

The mechanism of reporting and registration is as follows: the miniature film is taken and the diagnosis made; the patient is reported to the health department and advised to see his physician, who will decide what sort of treatment is indicated, if any. Many of these patients will need no treatment except periodic x-ray and clinical observation. If the lesion remains stationary or retrogresses, no change in the mode of living may be indicated. On the other hand, the patient with a minimal lesion may be said to be undernourished. A régimé of decreased effort and proper food may make long bed rest unnecessary. Doubt as to the activity of the lesion may be resolved by serial observations while on a modified program of this sort. Usually advising a patient to go to bed immediately after dinner and asking him to remain in bed on week-ends will suffice to bring about an increase in resistance and control the early noninfectious lesion. In patients with a positive sputum, however, who are dangerous both to themselves and to the community at large, strict bed rest may be necessary and the question of sanatorium treatment must be considered.

SANATORIA

The great increase in public sanatoria in California has made it possible for almost everyone in need of sanatorium treatment to receive it regardless of his economic status. Patients whose homes are unsuitable for their care either because of the presence of children or for other reasons, and who are financially unable to enter a private sanatorium certainly should be urged to seek care from one of the excellent city or county institutions presently available. The widespread use of collapse therapy in the modern so-called dynamic treatment of pulmonary tuberculosis makes this highly desirable.

SURGERY

The increasing importance of conservation surgical procedures, especially thoracoplasty, in the rapid rehabilitation of tuberculous individuals is now generally appreciated. It is possible that surgery in the treatment of tuberculosis is somewhat over-emphasized at the moment, but in well selected and properly managed cases it undoubtedly is of inestimable value in shortening the period of invalidism, in lessening the hardship incident to the disease as far as the family is concerned, and in lessening the cost of the cure both to the patient and to the community. Since these procedures are usually undertaken only in centers devoted to the treatment of the tuberculous, it is highly important for the physician treating this disease to know when such procedures may be indicated and to see that they are secured when advisable.

THE IMPORTANCE OF CONTACTS

The points previously stressed have led to the discovery of many collateral cases through the examination of contacts. This includes the x-ray examination of all those with whom the patient has been in intimate contact, especially members of the family. It is now generally appreciated that there are two problems in treating the tuberculous: (1) the cure of the inidvidual, and (2) the prevention of infection as far as the rest of the community is concerned. From the sociological standpoint the latter is, of course, the most important, and no family physician, therefore, may be said to have done his duty unless he has provided for the proper examination of contacts once a case of tuberculosis has been called to his attention. With infants the tuberculin test is enough With older children and adults, some form of x-ray examination is indispensable.

TREATMENT

The actual treatment of the individual afflicted with tuberculosis in war time is, of course, no different than in any other period as far as the application of the general principles of rest, good food and fresh air and the appropriate use of collapse measures are concerned. It is admittedly difficult for tuberculous patients to reach that stage of mental relaxation which is so highly desirable, and it is hard to see how the emotional tensions of this period can fail to effect the tuberculous as well as everyone else. Adequate nutrition presents another serious problem. For years it has been customary to feed the tuberculous individual a liberal, well-balanced diet rather high in protein and sometimes extremely high in cholesterol, as for example eggs and cream. It certainly is advisable to give tuberculous patients a fairly high protein diet and to see that at least a quart of milk daily is included in the diet. Where these cannot be obtained through normal sources I believe that the physician is justified in asking ration boards to make the diet adequate. It is well to remember the old dictum of Lawrason Brown that patients who gain up to ten to twenty pounds above their normal weight seldom break down again. This certainly applies to patients below forty years of age. After forty it is probably inadvisable to allow patients to gain much more than their theoretic normal.

ENFORCED ISOLATION

Recalcitrant tuberculous patients have long constituted a serious public health problem which is intensified during war time because of the eagerness of employers to hire as many employees as possible, and the desire of the individual to make as much money as he can. Under these conditions it is not surprising that many patients leave

(Concluded on Page 234)

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Brig. Gen. Hillman Assumes Command of Letterman General Hospital, San Francisco

Completing his work on his fifth anniversary as Chief of the Professional Service of the Office of the Surgeon General, Brigadier General Charles C. Hillman left Washington on August 7th to take up his new post on or about August 20, as the Commanding General of Letterman General Hospital in San Francisco. This institution—containing 2,500 beds—has been designated as the principal debarkation hospital for casualties from the Pacific area. General Hillman will succeed Brig. General Frank W. Weed, who will soon retire. Major General Norman T. Kirk, Surgeon General, U. S. Army said today that "General Hillman's assignment as the Commanding General of this important hospital on the West Coast illustrates the Army's concern with the care of sick and wounded soldiers. It is of paramount importance that such work be carried out under the direction of a medical man of wide experience and sound judgment. He has ably directed our Professional Service, being mainly responsible for the initiation of the blood plasma program of the Army, resulting in saving the lives of thousands of American soldiers; under his direction was organized the chest x-ray examination of all Army inductees, with a lowering of the incidence of tuberculosis among military presonnel to less than one-tenth that in World War I." "It is a happy coincidence," he observed, "that the qualities of administrative ability and sound medical judgment are thus combined in one man."

General Hillman obtained his doctorate of medicine from Rush Medical College in 1911 after graduating from the University of Arkansas. Following his internship in the Cook County Hospital he entered the Army Medical Corps in 1912. His assignments have been largely professional in character in important medical centers of the Army. His service has included several years at tropical stations during the years of peace and inspection of medical services in overseas theaters in the current emergency.

Navy to Spend $1,500,000 Improving Two California Hospitals

Banning and Beaumont Institutions Opened to Begin Receiving Battle Zone Casualties

Scheduled improvements amounting to nearly $1,500,000 will be rushed to completion at the Navy's new convalescent hospitals here and at Beaumont, the Navy recently disclosed.

The hospital sites, taken over from the Army a few weeks ago, will house nearly 2,400 Navy, Coast Guard and Marine Corps battle veterans, principally from the South and Central Pacific combat zones. A corps of nearly 900, including 60 officers, 100 Navy nurses, 575 hospital corpsmen and more than 160 civilian workers, will staff the two hospitals, which are just six miles apart.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

Breakdown on expenditures planned for the Banning Hospital involves $485,000 for alterations and repairs, in addition to $320,000 for new construction. This figure includes a large swimming pool, an important part of the establishment recreation setup.

Proportionate amounts will be expended for alterations, repairs and equipment at the Beaumont Hospital, as both plants were constructed by the Army for temporary training use and must be improved extensively.

Rear-Adm. George C .Thomas (M.C.), U.S.N., 11th Naval District medical officer, spoke at both of the commissioning ceremonies.

"This hospital, as one of many, is endeavoring to restore to good health these Navy veterans so they may return either to active duty or to civilian life," Capt. W. H. Short, U.S.N., said. He pointed out that patients treated at Banning will be those recovering from respiratory ailments, sinus infections and arthritic conditions, because of the ideal, dry climate which prevails in the area.

Estimated Principal Causes for Rejection of Registrants 18-37 Years of Age in Class IV-F, as of May 1, 1944

(Preliminary)

Principal Cause for Rejection	*Number*	*Per Cent*
Total	4,049,000	100.0
Manifestly disqualifying defects	425,700	10.5
Mental disease	657,100	16.2
Mental deficiency*	563,300	13.9
Physical defects	2,345,200	58.0
Musculoskeletal	303,500	7.5
Syphilis	286,800	7.1
Cardiovascular	261,600	6.5
Hernia	229,000	5.7
Neurologic	208,600	5.1
Eyes	206,100	5.1
Ears	156,100	3.9
Tuberculosis	107,700	2.7
Lungs	69,600	1.7
Underweight and overweight	60,700	1.5
Feet	51,700	1.3
Abdominal viscera	50 600	1.2
Kidney and urinary	41,900	1.0
Varicose veins	40,700	1.0
Genitalia	40,400	1.0
Endocrine	38,800	1.0
Teeth	35,800	0.9
Skin	24,900	0.6
Neoplasms	24,900	0.6
Nose	24,300	0.6
Gonorrhea and other venereal diseases	18,200	0.4
Hemorrhoids	16,500	0.4
Mouth and gums	11,000	0.3
Infectious and parasitic	4,200	0.1
Throat	4,000	0.1
Blood and blood forming	3,800	0.1
Other medical defects	23 800	0.6
Nonmedical defects	57,700	1.4

*Includes registrants rejected for educational deficiency before June 1, 1943, and for failure to meet minimum intelligence standards after that date, as well as those rejected for mental deficiency.

—*Journal of the American Medical Association.*

Blood Saves Lives

At a time when the run on the American Red Cross blood bank is reaching its highest point on the critical battlefields, there is a slackening tendency in blood contributions in all parts of the country.

This should *NOT* happen.

If this slackening tendency continues, it will cost American lives.

Surgeon Gen. Normal T. Kirk of the United States Army most urgently reminds the American people that the blood plasma quota has been stepped UP, not down; that there is a minimum demand of 106,000 pints of blood a week for the armed forces.

This is an obligation of the entire American people, and it cannot be defaulted.

Casualties Are Near a Half Milion

Washington, Oct. 19 (U.P.)—American war casualties neared the half-million mark today with announcement by the War and Navy Departments of new figures which brought the overall total to 453,375, of which 102,609—or about 25 per cent of all casualties—are listed as killed or died of wounds.

Total Army casualties in all theaters through October 6 were 384,895—75,562 killed or died of wounds, 208,392 wounded, 48,404 missing and 52,537 captured and interned. This total represented an increase of 33,602 over figures announced a fortnight ago, an increase ascribed in part to a revised and improved statistical system which permitted more up-to-date reports.

Announced Navy casualties as of today (Navy, Coast Guard and Marines) were listed as 68,480, including 27,047 died, 27,367 wounded, 9,586 missing and 4,480 prisoners.

The War Department also announced that Army casualties in France, Germany and the low countries from D-day through October 3 totaled 174,780, not including air forces casualties. The total figure included 29,842 kliled, 130,227 wounded and 14,711 missing.—San Francisco *Chronicle*, October 20.

Military Clippings—Some news items of a military nature from the daily press follow:

Sacramento Hospital Unit Is Aiding Reconquest of France

The Sacramento evacuation hospital unit, composed mainly of Sacramento doctors and nurses, recently celebrated its second birthday with active participation in the invasion and conquest of southern France.

Dr. E. T. Rulison of Sacramento revealed he has received several cables from members of the group reporting their progress through southern France where they operate a 700 bed hospital under field tents.

The unit, known in the army as the 51st Evacuation Hospital, is composed of 40 doctors, 40 nurses and 500 enlisted personnel and was organized by Lieutenant Colonel Orrin S. Cook, veteran of World War I and former president of the Sacramento Chamber of Commerce.

Surgeon in chief is Lieutenant Colonel Donald McNeil, a former orthopedic surgeon.

Organization of the unit was begun shortly after Pearl Harbor by Colonel Cook. The members were trained in Fort Lewis, Wash., under their commander, Colonel H. A. Weller of the regular army.

In January, 1943, the unit was transferred to Needles, where they received training under desert conditions until July. The unit moved in July, 1943, to Banning, near Riverside, where it operated as a general hospital until November.

The final stop before embarkation was in Camp Cooke at Santa Maria where they stayed from November, 1943, until January, 1944.

Overseas the evacuation hospital was stationed in North Africa, near Oran, for three months.

In March the unit was transferred to Italy where the personnel worked as a general hospital near Naples until the invasion of southern France.

The unit is attached to the army of Lieutenant General Alexander M. Patch, Jr.

Syphilis and its cure by injunction was described by Luis Lobera d'Avila, who lived about 1551, and was physician in ordinary to Charles V.

COMMITTEE ON INDUSTRIAL PRACTICE

Re: California Industrial Accident Commission Surcharge

Physicians who have experienced difficulty in securing payment in full (including the 15 per cent surcharge) for compensation cases from certain insurance companies will be glad to learn that at least one of the recalcitrant companies has apparently changed its tactics and is now allowing the surcharge item.

Letters sent to the C.M.A. by several members show that where the physician has declined to accept the company's check—with the 15 per cent deducted—and has returned the check with a demand for payment in full, this company has responded by tendering a check in full payment of the statement, including the surcharge.

This experience bears out the wisdom of the physicians acting in unison and collecting these fees. It also emphasizes the suggestion made by the C.M.A. Committee on Compensation Fees that all physicians should take a firm stand in demanding that all insurance carriers pay the 15 per cent surcharge ordered by the Industrial Accident Commission. To date, four insurance companies have been reported as either refusing to pay the 15 per cent surcharge or demurring before paying it. Now, one of those four seems to have reversed its tactics; at least, it is paying the surcharge where it is demanded by the physician.

The C.M.A. office is interested in receiving further letters along this line. It is prepared, in turn, to assist any member in filing a protest and a disputed fee statement with the California Industrial Accident Commission if such a procedure is necessary. Again, it is urged that all physicians act together for the good of the common cause. Back up the Industrial Accident Commission and the C.M.A., and more adequate and fair fees for compensation work are bound to result.

California State Compensation Fund

Large Refunds of Premiums to Policyholders

Paul Scharrenberg, Director of Industrial Relations, has announced that on October 2, 1944, in accordance with the provisions of the Workmen's Compensation Act, the State Compensation Insurance Fund will begin its annual refund to California employers, returning the excess premiums collected during 1943. The Fund operates on the basis of furnishing insurance to employers at cost. After the payment of full compensation and medical benefits to injured workmen and making provision for claims reserves and a reasonable surplus for catastrophe hazards, the remaining surplus premiums are returned to the policyholders. The total sum to be refunded this year will exceed $5,000,000, the largest amount for any year since the Fund was established in 1914.

Mr. Scharrenberg, who is also Chairman of the Industrial Accident Commission, the Fund's Board of Directors, stated further, "A favorable accident experience resulted from an effective program of safety engineering and public safety education. In combination with low operating cost and the largest premium volume of any compensation carrier in California the Fund is in a position to continue.

Insurance Law on Workmen Under Fire

Los Angeles (A.P.)—A State Assembly committee hearing, announced as a preliminary to a possible complete revamping of the California Workmen's Compensation Act, was opened here yesterday.

In an opening statement, Assemblyman Albert M. King of Oroville said the Act was adopted at a time when there were only 900 claims a year for benefits to injured workmen.

He said the law has now become outmoded and inadequate to cover conditions under which the State Industrial Accident Commission is now required to settle 20 000 claims a year.

Hartley Peart, legal counsel for the California Medical Association, testified that medical fees for treatment of industrial cases are too low at the present time.

Assemblymen Frank Waters, Los Angeles, and Clyde A. Waters, Orange, are other members of the committee.
—Sacramento *Union*, October 4.

COMMITTEE ON POSTGRADUATE ACTIVITIES

War-Time Graduate Medical Meetings

While the War-Time Graduate Medical Meetings have continued to carry on their important function, we are approaching a period in which renewed effort is important. With the increase in the duties of the medical personnel of our Army and Navy hospitals in the United States and the necessary reduction of the number of physicians at the representative units, comes increased difficulties in arranging for meetings. Every effort should be made to enlist the coöperation of civilian physicians to the end that these meetings may be taken to the military and navy units rather than ask service men to leave their posts for any length of time. At all events, the need for this type of meeting is more acute than ever and we cannot relax our efforts in this direction.

The regional directors are urged to inform the Central Committee of the status in their respective areas. Prompt and early information concerning future programs will facilitate publicity and act as a stimulant to other regions.

Regional activities follow:

* * *

Region No. 23 (Nevada, Northern California)—Dr. S. R. Mettier, Chairman; Dr. E. H. Falconer, Dr. D. N. Richards.

A War-Time Graduate Medical Meeting was conducted at the DeWitt General Hospital on September 13. Dr. Howard C. Naffziger lectured on "Peripheral Nerve Lesions and Their Treatment" and also held a clinic centered around several patients at the hospital. Dr. H. Glenn Bell discussed "Early Ambulation of Post-operative Patients" on the same program. Approximately eighty physicians attended this meeting, which was very well received.

Region No. 24 (Southern California)—Dr. W. A. Morrison, Dr. J. F. Churchill, Captain H. P. Schenck.

U. S. Naval Hospital, Santa Margarita Rnach, Oceanside, California:

October 16—Audio-Visual-Kinesthetic Methods in the Rehabilitation of the War Deafened—Lucelia M. Moore.

The September program at this installation was conducted by Dr. Carl W. Rand, who spoke on "War Wounds of the Head: Comparison of Methods Used in World War I with Present Methods."

U. S. Naval Hospital, Long Beach, California.—October 21—Some Aspects of the Treatment of Peptic Ulcer—Dr. William C. Boeck.

On August 31 a meeting was held at the U. S. Naval Hospital, San Diego, featuring a paper by Dr. Sterling Bunnell on "Lesions of the Hand." The second program in the fall series at this installation took place on September 14, at which time Captain J. P. Owen spoke on "Amputations and Prosthetic Appliances." Motion pictures were also exhibited.

Heart Committee of San Francisco Tuberculosis Association

A form of typhus infection hitherto known only in

Japan and in the South Pacific—and for which there is no known successful treatment—is being encountered in the Pacific fighting zones by American soldiers, Lieutenant Maurice Sokolow of the U. S. Naval Hospital, Oakland, told a conference of western physicians on October 26.

The Navy doctor's paper was one of a series read at the first session of the fifteenth annual postgraduate symposium on heart disease sponsored by the heart committee of the San Francisco Tuberculosis Association, at the University of California Hospital.

He said the disease, called "scrub typhus," is transmitted by small insects, is of lengthy duration and weakens the heart.

Dr. Maxwell M. Wintrobe, professor of medicine at the University of Utah, told the hundreds of assembled physicians that illnesses diagnosed as heart ailments many times are actually only "by-products of anemia, and that relief can often be obtained by treating the anemia rather than the heart itself."

Dr. Wintrobe also discussed a strange heart ailment known as "sickle cell anemia." which he said affects only Negroes, causes the red blood corpuscles to assume a curved or sickle shape, and produces heart symptoms like those in rheumatic fever.

Dr. Henry Brainerd of San Francisco Hospital described another baffling heart difficulty, resulting from a streptococcus infection of the heart's inner lining.

He said doctors are working with sulfa drugs and penicillin to combat it, but that a successful treatment has not yet been devised.

Dr. Leslie Bennett of the University of California medical faculty said certain heart cases whose predominant symptom is a swelling of the lower body, have been successsfully treated by elimination of salt from the diet.

San Francisco Psychoanalytic Society

The scientific program of the semi-annual meeting was held on Saturday and Sunday, October 28, 29, 1944, in the Ambassador Hotel, Los Angeles, California.

Program follows:

SATURDAY, OCTOBER 28, 1944
Symposium
SHORT PSYCHOTHERAPY
"Experiences with Short Psychotherapy in Military Psychiatry."
Commander U. H. Helgesson (MC) USNR
"The Practice of Short Psycholanalytic Psychotherapy"
Dr Bernard Berliner
"Theoretical Considerations of the Indications, Limitations and Technique of Short Psychotherapy."
Dr. Otto Fenichel and Dr. Ernst Simmel
Discussion opened by Major William G. Barrett, M. C.

SUNDAY, OCTOBER 29, 1944
"The Possibilities and Limitations of Group Psychotherapy."
Dr. Emanuel Windholz
"Vestigial Roots of Schizophrenia."
Dr. J. S. Kasanin
Discussion opened by
Lt. Comdr. J. Clark Moloney, (MC) USNR

American College of Surgeons Expands Graduate Training Program

In expanding its program of Graduate Training in Surgery to assure adequate opportunities for advanced training in surgery, particularly for recent medical graduates when they return from service with the armed forces, the American College of Surgeons has enlarged its headquarters staff in Chicago. . . .

Surveys of hospitals for Graduate Training in Surgery have been conducted since 1937 by the College. When the war ends in Europe, in order to satisfy the demands of men whose training in surgery was interrupted by war service, together with those of current medical graduates, sufficient opportunities should be ready to offer approved training to men who wish to become surgeons, Dr. MacEachern declares, adding that a competent surgeon according to present day ideas requires a preparation of three or more years of systematic, supervised graduate training in general surgery or a surgical specialty, following a general internship and graduation from an acceptable medical school.

Distinguished British Military Psychiatrist Will Deliver Salmon Lectures for 1944

Brigadier General J. R. Rees, Consultant Psychiatrist to the British Army, delivered the Salmon Lectures for 1944 at the Academy of Medicine, 2 East 103rd Street, in New York on three successive Friday evenings—November 20th, 21st and 22nd at 8:30 P.M.

The Salmon Committee on Psychiatry and Mental Hygiene, appointed by the Council of the New York Academy of Music, annually invites an outstanding specialist in the field of psychiatry, neurology, or applied sciences, who has made the greatest contribution to his specialty during the preceding year, to deliver the lecture series.

Following these lectures at the Academy of Medicine in New York, Brigadier Rees is touring the country and will present condensations of the three Salmon Lectures. Among cities to be visited is Los Angeles, where on November 30th Brigadier General R. J. Rees will appear before the Los Angeles Academy of Medicine.

Public Health School Formed in California

Establishment of a school of public health in the University of California was announced recently by President Robert G. Sproul. This is the first school of public health on the West Coast and culminates nearly 15 years of effort by the Western Branch of the American Public Health Association and many other organizations that have been interested and helpful in establishing such a school.

The new school was set up by the Board of Regents after the State Assembly passed a bill appropriating funds for the proposal. Dr. Walter H. Brown, chairman of the department of hygiene, has been appointed acting dean.

Planned as a university-wide undertaking, using the resources of all campuses, the school is being organized as a coöperative enterprise, and involves the participation of other departments and schools, including medicine, medical research, education, nursing, home economics, and sanitary engineering. Courses and curricula are being planned both for graduates and undergraduates. Plans will be developed for the graduate training of health officers, epidemiologists, public health engineers, industrial hygienists and other specialists.

The first official activities of the school are concerned with special training courses to meet war emergency course for sanitarians.

The Coördinator of Inter-American Affairs has made arrangements to send 15 students representing 12 Latin American countries to take a course to prepare them for public health education in their own countries.—Victor *News.*

The first to suggest the extirpation of cancer by means of a preparation containing arsenic was Valescus de Taranta (*ca.* 1470-1490). He was the author of a treatise on the plague and *"Philonium,"* a work on medicine and surgery in seven books.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

"Political" Medicine Hit

Medical Group Head Scores U. S. Proposal

"Political domination of medicine will result in the people's getting third-rate, or fourth-rate, care—for under such domination, progress becomes stifled, ambition is curtailed and less gifted individuals are attracted to the profession."

So Dr. Lewis A. Alesen, president of the Los Angeles County Medical Association, told the graduating class of the College of Medical Evangelists at a banquet in the Biltmore Hotel on September 1.

Dr. Alesen, denouncing contemplated governmental legislation which would give control over some phases of medical and hospital practice to the Surgeon General of the United States, further declared:

"The government apparently lacks understanding of the human individual, his reaction to responsibility and his degeneration under paternalism.

CURB ON PROGRESS

"If medicine is politically dominated, the profession would go ahead only in a hap-hazard, desultory fashion. Progress does not come through alleged security but rather through venturesomeness and willingness to chance in order to achieve something better."

Dr. Alesen cited 16 statewide and three partly statewide plans, already in operation and developed by medical societies, which provide prepaid medical care. Five other statewide plans offering similar, low-cost service are soon to be launched, he said.

American Bar Association's Report on Wagner-Murray-Dingell Bill (S.1161)

The American Bar Association is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. Under normal circumstances, therefore, it is not the function of this Association to attempt to influence substantive legislation by the Congress of the United States. But when, under the pretext of the general welfare, legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country, it becomes the duty of this Association actively to voice its objections, a summary of which is as follows:

1. Local self-government must be preserved in our Federal system. State governments directly responsible to the will of the people are best adapted to exercise such supervisory control as may be instituted over the health and medical care of our citizens.

2. S. 1161 seeks to invest in the Surgeon General, who is not an elected servant of the people and who is not amenable to their will, the power arbitrarily to make rules and regulations having the force and effect of law which directly affect every home.

3. The measure furnishes the instrumentality by which physicians for their practice, hospitals for their continued existence, and citizens for their health and that of their families can be made to serve the purposes of a Federal agency.

4. The bill fails to safeguard the rights of patients, citizens, hospitals, or doctors with respect to disputes arising or rights denied through the arbitrary or capricious action of one man.

5. The bill fails to provide for any appeal to any court from the action of the Surgeon General.

6. The vicious system whereby administrative officials judge without court review the actions of their subordinates in carrying out orders issued to them is extended in this bill to a point foreign to our system of government and incompatible with the adequate protection of the liberties of the people.

The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent, when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear upon them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates.

If the socialized-medicine bill had been in effect in 1942, the following would have resulted:

Social Insurance Contributions

(a) By employers and employees	7.168 Billion Dollars
(b) By self-employed	.917 Billion Dollars
Total	8.085 Billion Dollars
(c) By state and local governments and employees	.259 Billion Dollars
Total	8.344 Billion Dollars

Of the foregoing taxes there is required to be credited to the Medical Care and Hospitalization Account:

¼ of (a)	1.792 Billion Dollars
3/7 of (b) and (c)	.547 Billion Dollars
Total	2.339 Billion Dollars

We come now to the number of people covered by the scheme:

Total employed in industry	44.9 Million
Total employed by state and local governments	3.3 Million
Total employed under Railroad Retirement Act	1.4 Million
Total self-employed	10.8 Million
Total Covered	60.4 Million

If every individual worker is covered by this act (as it appears he may be if his earnings are at a prescribed minimum), coverage must include practically all families in the United States. So with virtually complete family coverage by the act, there would be few or no patients left for physicians who prefer private practice to becoming a part of the socialized-medicine scheme.—*The Christian Science Monitor.*

Insurance on Health Asked

Congress will be asked when it reconvenes in November to approve a federally-financed compulsory health insurance program for the nation's needy.

Representative Miller (R.-Neb.) disclosed that the measure is drafted and ready for presentation to Congress, bearing the endorsement of Arthur J. Altmeyer, social security board chairman.

Miller's bill would cost the Federal Government an approximate fifteen million dollars—or 3 per cent of the estimated half billion dollars now granted states for medical care of the aged.

"People receiving old age asssitance are not getting adequate medical care," Miller contended. "There is considerable red tape in showing they need it and three to ten dollars provided usually is spent for food and clothing.

"Money paid now for medical aid, if slightly supplemented by the Government, would buy a good insurance policy for medical, surgical and hospital care."

Miller said he plans to broaden the bill to assure the post-war unemployed as well as the aged medical care by doctors of their choice.

Magnus Hundt (1449-1519) studied philosophy, medicine and theology at Leipzic. In his principal work, "*Nuetzlich Regiment*," published in 1509, there are references to syphilis and the sweating sickness.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Labor Organizations and Medical Care

Following are excerpts from the *"News Letter"* of Northern California Union Health Committee, 57 Post Street, San Francisco (4), of date of October 25, 1944 (Vol. 1, No. 9). These items from the 12 page *"News Letter"* reflect the present and active interest shown by Labor organizations in medical and hospitalization service and other activities related to the existing system of medical practice:

Statistics.—It isn't often that statistics rouse more than passing interest, but not so with those released to the Committee by Miss Leona True, Director of the TB Division of the San Francisco Department of Public Health.

A total of 3,650 waterfront workers were tested in the month's survey, about which so much interest was displayed on the part of union members. Out of this large total, there were a remarkably small number of positive Tb findings, the percentage less than half the national average, proving our longshoremen to be a healthy crew in this respect. The Public Health nurses have followed up most of the positives: two men have been hospitalized, others are being observed by their doctors. Miss True told the Union Health Committee that she was much impressed by the union sponsorship of the survey and considered it to have been fine health education and a good use of public health facilities. . . .

Public Health Nurses Join Trade Union.—A majority of the public health nurses employed by the San Francisco City Health Department are now organized. Through the efforts of business agent Steve Hamilton, they form the Nurses' Section of SCMWA, Local 503, CIO. The unit was formed in September and recently held its first membership meeting at which they were addressed by NCUHC Executive Secretary Marianna Packard. A mutual interest in close coöperation with the Union Health Committee was expressed, and it is expected that a union health committee will be formed within the section to make that coöperation effective.

Officers of the union are Doris Robinson, chairman, Mary Coyne, vice-chairman, Noelle Anderson, recording secretary, Marie Margot, sergeant-at-arms, CIO Council delegate, Mary Kern, with an executive committee composed of Margot Dieser, Rachel Sohl, and Helen Wilson.

Members of the union tell us that their first aims are naturally adjustments of wages, improved working conditions, matters of retirement provisions and vacations, and so on. A long term program is being worked out, to include such activities as an educational campaign to acquaint the public (and labor) with the duties and responsibilities of public health nurses. From the union itself will come increased impetus for the maintenance of high nursing standards, according to union spokeswomen. . . .

Permanente Hospital Staff Activities.—Leif Thorne-Thomsen, labor representative on the staff of Permanente Hospital, tells the Committee that attendance at the classes being given at the East Bay Labor School by Permanente doctors is on the increase.

Dr. C. C. Cutting, of the staff, will lecture October 23 at 8 p.m. on Recent Advances in Medicine and Surgery; Dr. E. E. Levine speaks October 30 on Health Problems after 40.

Dr. Sidney Garfield, medical director of the Permanente Foundation, will speak Monday evening, November 6th, on *Bringing More and Better Medical Care to More People.* This lecture will be handsomely attended, according to the School. No charge has been made for this course, which has as its purpose the stimulation of interest in better health and medical care among the people of the East Bay community. . . .

The National Scene.—*A significant report on National Health Program* was adopted by the American Public Health Association at its annual meeting in October. The report recommended a national program offering the complete services of general practitioners, specialists, laboratories, hospitals and dentists to people in all areas of the country.

Recognizing the present inadequacies in personnel and facilities, the report states that the ultimate goal may not be obtained immediately but within ten years. Meanwhile, financial assistance should be given for training and personnel and for building necessary physical facilities.

To raise money for the provision of care and expansion of resources, the report recommends financing "through social insurance supplemented by general taxation or by general taxation alone."

Of particular interest to labor are these facts:

1. The people's contribution to such a program might be payment by the same means provided for in the Wagner-Murray-Dingell Bill—through social security deductions."

2. The payment to doctors would be as proposed in the WMD Bill—"Private practitioners in each local administrative area should be paid according to the method they prefer, i.e., fee-for-service, capitation, salary or any combination of these."

But the APHA report recognizes what labor has long felt through its experience, "that fee-for-service has a history of unsatisfactory results."

3. Professional public health workers through their organization, the APHA, are now publicly taking a stand on medical care as well as public health.

That position stems from the APHA Subcommittee on Medical Care, whose chairman is Dr. Joseph Mountain of the USPHS, and which includes such other experienced public health men as George Perrott and Nathan Sinai. For their leadership they have already received a blast from the organized medical profession. Morris Fishbein, editorializing for the A.M.A., says of the report, "Perhaps this step . . . will be useful in serving notice of the political manipulators in the fields of social security and public health whom the medical profession will be forced to combat." . . .

CIO Testimony on Nation's Health.—Two representatives of the CIO, Robert Lamb, Legislative Director of United Steelworkers of America, and Albee Slade, Legislative Representative of the Los Angeles CIO Council, appeared before the Senate Subcommittee on Wartime Health and Education in September.

The NCUHC has just received from headquarters a copy of the National CIO statement entitled—*Memorandum on the Need for Better Medical Care.* It states first that there is a need for collecting more information on the actual cost of providing medical care in localiites and regions. It contains careful facts on selective service rejections, the inadequacies and maldistribution of medical facilities and personnel and on the inability of large numbers of people to purchase adequate care.

Citing labor's position, it says, "To overcome the economic consequences of the uneven incidence of medical costs, those costs should be met through insurance or public medical services. . . . While insisting on a national program, labor has not lost the chance to do what it can to ameliorate the present neglect." Pointing to the objectives of union sponsored programs, the statement cites offering of physical examinations to referred workers, promoting safety programs, and aiding rehabilitation programs.

Albee Slade's presentation set forth as an initial point that the achievement of a satisfactory level of national health requires a three point program involving Federal assistance in financing.

"The first is the provision of adequate hospital and sub-hospital facilities, properly distributed throughout the country.

"The second essential is adequate and completely accessible medical care, available to all, through systems combining group practice by physicians and group prepayment by the consumers—the public.

"The third essential is public subsidy for the professional education of medical students and for postgraduate study at regular intervals by physicians in practice."

Slade held that subsidization of medical education is necessary to reduce the cost of providing medical attention.

Reflecting conditions in California as illustrations of unsuccessful patterns, Slade criticized the California Physicians' Service and the State Procurement and Assignment Service under the War Manpower Commission. In both cases instances were cited as demonstrations of failure to meet the needs of production workers and vital industrial communities. (Note by Ed. CALIFORNIA AND WESTERN MEDICINE.—For cross reference, see footnote on page 206 in October, 1944, CALIFORNIA AND WESTERN MEDICINE.)

In a letter to the Union Health Committee, Slade wrote, "I hope that the results of these hearings will be of great importance not only to organized labor but to all of our people. . . . I would like, therefore, to express my appreciation for the very able assistance lent by your Committee in designating Miss Stein to help and prepare for the hearings. Her thorough knowledge of recent developments throughout the nation in the field of medical care . . . was of inestimable aid." . . .

Public Health Agencies Meeting in San Francisco

Scores of San Francisco agencies and professions concerned with public health met on October 18, at the city's first Institute on Public Health Education to work out a lasting program for better health through knowledge.

They gathered under the guidance of Dr. Clair E. Turner. Pointing out that public health education pays for itself many times over in lowered community expenses for care of the sick, Doctor Turner said:

"We find that numberless persons are needlessly ill because they unnecessarily expose themselves to infection, because they fail to get the needed food elements, because they depart from basic principles of mental hygiene and because they substitute fads and self-medication for hygienic living and scientific medicine."

Doctor Turner was lent to San Francisco for the two day Institute by the Office of the Coördinator of Inter-American Affairs, for which he is chief health education officer. Principal purpose of his talk was to outline methods for carrying out public health education on a communitywide basis.

Sessions were held at headquarters of the San Francisco County Medical Society, 2180 Washington Street. The Society is sponsoring the Institute jointly with the city department of public health.

Dr. Rodney M. Beard, chairman of the Institute's committee on arrangements, said a principal aim of the health education program is illustrated by San Francisco's current need for sewer improvements.

"We are proposing to vote bonds for better sewers;" he said. "It does little good for various officials to say we need them. There must be a general public understanding that such sewer improvements are essential to public health."

Doctor Turner said newspapers are one of the "main voices" of public health educators.—San Francisco *Examiner*, October 18.

Raw Milk Banned by City Council of San Jose

By a vote of six to one, the San Jose city council recently adopted an ordinance prohibiting the sale of raw milk in San Jose. . . .

Council President E. H. Renzel, Jr., raised the question whether an ordinance requiring producers of raw milk to have their herds certified as free from tuberculosis, Bangs disease and mastitis would meet with their favor. The latter bovine ailment was connected in the discussion with "strep throat" in human beings.

This was answered by Frank J. Corriea, who operates a 50-cow dairy on the Bayshore highway to the effect that he would have no objection. . . .

To clarify this point he called attention to a statute which was on the city books from 1923 to 1937, promulgated as a health measure and requiring that milk sold as pasteurized must be treated in side the city limits. While the ordinance was in effect, licensed producers were also selling raw milk inside the city limits. After 1937, pasteurization in a radius of 15 miles outside the city limits became legal. . . .

Carter read a copy of the letter which he directed to the American Medical Association, Dr. Karl F. Meyer of the Hooper Foundation, San Francisco, the California Tuberculosis Association, Dr. Charles Smith of the Stanford University School of Medicine and president of the State Board of Health, Dr. C. S. Mudge of the University of California Agricultural Experiment Station, the California State Medical Association, County Medical Society, Dr. Charles Ianne of Stanford School of Health, Dr. Wilton Halverson, California State Health Department, Dr. Edward Kupka, state director of tuberculosis, Arthur Hayes, State Department of Agriculture, Dr. Gerald Scarborough, director of the County Tuberculosis Clinic, Dr. Buford Wardrip, Alum Rock Sanitarium, Dr. Thomas Parran, surgeon general of the U. S. Public Health Service, and Dr. Kendal Emerson of the National Tuberculosis Association.

The authorities were unanimous in favoring pasteurization, he declared, reading excerpts from two of the most complete answers received.

Carter included in his letter questions on all the major objections raised by opponents of pasteurization. Opinions developed by this question and answer method:

Rigid inspection alone will not adequately protect the health of the community. Neither will pasteurization, unless it is accompanied by rigid inspection. No epidemic was ever traced to *properly* pasteurized milk. Pasteurization lessens certain food values, but not in a manner to injure health. . . .

On the question of the comparative taste of raw and pasteurized milk Dr. Smith wrote:

"The fine, rich flavor of raw milk, which its adherents praise, is really the fine, rich flavor of cow manure, which is volatilized off in pasteurizing."

Carter's authorities declared that pasteurization enhances the keeping quality of *good* milk, and said that if milk "putrefies" instead of souring, it was not clean milk to begin with.

Similar points were made by Dr. Harlin Wynns, epidemologist of the State Board of Health, present as a guest speaker, who said:

"Early day pasteurization methods were not as safe as they are at present. If the process is not carefully controlled so that the temperature does not go above 145 degrees, there are taste changes. This is not true, below that temperature, provided the milk was good and pure in the first place. There is a mechanical factor in pasteurization which may fail. Inspection will correct objectionable milk production practices, but it will not detect the presence of typhoid germs."

A Personal Matter

Dr. E. H. Skinner, editor of the *Kansas City Medical Journal,* expresses some basic thoughts in connection with Federal socialization of medicine as proposed under the pending Wagner health bill. He points out that a survey of public opinion shows that a majority of people are concerned about finding methods of meeting unpredictable expenses of catastrophic illness, and says, "The politician and social workers offer government medical services as an answer to this developing demand. Insurance companies offer accident and health insurance. Industry or management offers contributory or participating disability insurance. Some groups of physicians offer attractive pre-payment schemes. Some county medical societies offer coöperative pre-payment methods.

"It is so easy to argue that the medical profession must accept the whole responsibility of extending and distributing all the services to all the people. But the responsibility must be shared by each of the basic factors in the whole problem.

"Government should encourage the people to accept solutions that are adapted to democratic economies, rather than promoting totalitarian mediocrity. . . .

"There can be no isolation of responsibility to medicine, to labor, to industry or insurance. The people themselves must accept and discharge their individual and collective responsibility by agreeing that good health and attention to their illness can never be a matter of governmental spending through bureaus."

Any health service based on shared expense, that is sound in principle, must be subject to actuarial proof and stabilization.

"Social security," including socialized medicine, is not an insurance policy. It is a matter of legislation that can be changed, shifted, sacrificed or bankrupted by the same legislators that created it.—San Francisco *Western Underwriter,* June.

Scarlet Fever and Streptococcic Sore Throat

The Significance of the Dick Test—Sulfadiazine Prophylaxis for Contacts

There have been over 1000 cases of scarlet fever reported to the Los Angeles City Health Department so far this year. Although there have been only three deaths in this group, the man hours lost and the permanent health damage that has resulted make this a very important disease.

Scarlet fever is the result of a throat infection with a toxin-producing hemolytic streptococcus in an individual susceptible to this rash producing toxin. The Dick test is merely an intracutaneous test for susceptibility to this toxin. The main damage to the human body is done, not so much by the rash producing toxins, as by the streptococcus itself through localization and abscess formation (otitis media, cervical adenitis, mastoiditis and sinusitis), by permanent kidney damage, and by activation of acute rheumatic fever.

The majority of contacts of scarlet fever are known to harbor in their throats the same streptococcus as the case itself. These people, because they are not susceptible to the toxin of the streptococcus, do not develop scarlet fever. They may, however, disseminate the organisms in the community, develop clinical streptococcus sore throat, or develop the same complications that result in the person with scarlet fever. The Los Angeles City Health Department recommends the prophylactic administration of small doses of sulfadiazine (i.e. gm. 2,2,1,1, in adults on four consecutive days) to all contacts of scarlet fever.—*Bulletin of Los Angeles City Health Department.*

Many Diets Fail to Meet Adequate Nutrition Levels

The Committee on Diagnosis and Pathology of the Food and Nutrition board of the National Research Council has reviewed material reported in widely scattered journals on the state of nutrition of the people of the United States. An appreciable percentage of diets fail to meet more than 50 per cent of the recommended daily allowances of the Food and Nutrition board, but many more diets are deficient by less than 50 per cent.

This widespread prevalence of more or less deficient diets is associated with a high incidence of different states of deficiency, largely mild in intensity and gradual in its course. The problem thus created is both preventive and corrective. For prevention, production of sufficient food must be maintained and better distribution is required; judicious enrichment of appropriate foods may be advisable, and dietary education should be intensified and extended. For correction there is need for skill in detecting deficiency conditions and improved procedure for the treatment of such conditions.

There has been some exaggeration of the benefits of the best nutritional standards and much exploitation of the vitamins. Knowledge of the relation of nutrition to health is being rapidly uncovered.

American People Give 30 Million Dollars in 11-Year Fight on Poliomyelitis

In the last eleven years the American people have contributed $29,562,742.54 to conquer infantile paralysis, Basil O'Conner, President of the National Foundation for Infantile Paralysis, announced on September 11 at the opening of the annual meeting of the Medical Advisory Committees of the National Foundation at the Waldorf-Astoria Hotel. At that meeting applications for grants to carry on medical research was considered and further plans for carrying on the fight against infantile paralysis was made.

Sixteen million dollars, or more than half of the total given, was raised in the two years of 1943 and 1944.

"Some idea of the scope and extent of the National Foundation's program of scientific research is shown by the fact that, since it was organized only six years ago, it has made 298 grants to 74 institutions involving 114 groups of workers, in one of the greatest scientific attacks against any disease."

During the past eleven years almost $15,000,000 of the total raised has been left with the counties where raised to provide the best in medical care for the thousands of new patients reported each year.

Of the remainder of this nearly 30 million dollars, the National Foundation received approximately 13 million dollars to conduct its programs of scientific research, education and epidemic relief. One-half has been used by the National Foundation for grants in research dealing with the virus, epidemiology and after-effects of infantile paralysis, education and epidemic aid as follows: virus research, $2,053,761; after-effects research, $1,405,292; education, $1,179,215; epidemics, $637,548; Tuskegee Institute, $404,256; Georgia Warm Springs Foundation, $825,000—total $6,508,475.

New Venereal Plan for San Francisco

The proposed ordinance to check venereal disease, presented to the San Francisco Board of Supervisors on October 20, would if adopted make it possible to strike at the source of 80 per cent of the cases now contracted, it was claimed by the proponents.

Explanation of the drastic measure was given by Dr. Geiger in a letter to City Administrator Brooks. It read:

"It is my feeling that the proposed ordinance which permits the police officers to apprehend a person on the basis of preliminary quarantine rather than to make it necessary for this police officer to accumulate adequate evidence for arrest, and which provides that all persons who are arrested be automatically quarantined by the Police Department, is of infinite value and in the interest of venereal disease control.

"It is important to point out that this ordinance safeguards the interests of the public by providing that such quarantine as established by the Police Department shall exist for a maximum period of 24 hours only, or until the Health Department has an opportunity to review the grounds and reasons for the establishment of such quarantine at which time the Department of Health, if indicated, will establish the diagnostic quarantine which may exist for a maximum period of 72 hours during which time the person will be examined for a venereal disease.

"This ordinance will make it possible for us to reach one of the largest sources of venereal disease, namely, those women who patronize bars and taverns and who are now responsible for at least 80 per cent of the venereal disease being contracted by the members of the armed forces and the civilian war workers."

The discoveries of healing science must be the inheritance of all. That is clear. Disease must be attacked whether it occurs in the poorest or the richest man or woman, simply on the ground that it is the enemy; and it must be attacked just in the same way as the fire brigade will give its full assistance to the humble cottage as readily as it will give it to the most important mansion.—Winston Churchill, *Lancet*, Mar. 11, 1944.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

California Women Urged to Enroll as Home Nurses

In the midst of San Diego's home nursing campaign, Mrs. Louise Graham, chairman, local Red Cross home nursing, on September 16 cited an appeal by Dr. Lowell S. Goin, president of the California Medical Association, to the women of California to do their part in safeguarding the health of the state by learning basic principles of home nursing.

He pointed out that, with 100,000 doctors and nurses now in uniform, citizens can be of inestimable assistance in relieving the pressure on civilian doctors through a working knowledge of home nursing and first aid, she said.

Goin revealed that the goal for California for the period July 1, 1944, to June 30, 1945, is 39,746 graduates in home nursing, to protect the home front adequately.

Los Angeles County Considers Giving Emergency Hospital Service for Cities in the County

Under consideration by the Board of Supervisors is the establishment of Los Angeles County-sponsored emergency hospital service in Long Beach as well as in all other cities of the county. The county manager, instructed by the supervisors, will examine the financial and administrative phases of a single unified system of emergency hospital service.

In an initiatory step toward such a program, supervisors have opened for admittance to emergency cases the well equipped hospital on the grounds of the County Farm north of Long Beach.

All cases requiring further hospitalization would be transferred later to the General Hospital in Los Angeles. Under the proposed plan, the hospital at the County Farm, which has in the past limited its services to the treatment of indigents, would serve the southern part of Los Angeles County.

New State Mental Health Board Is Proposed Here

The creation of a new state executive department of mental health was recommended to a conference of neuro psychiatrists and state department heads which convened in Sacramento on September 8 by Governor Earl Warren to help formulate an improved California program for meeting the problems of mental illness.

The suggestion came from Dr. W. L. Treadway, medical director of the United States Public Health Service in the Los Angeles district. Dr. Treadway urged such a department be headed by an experienced physician, adequately paid and given a tenure of office based upon ability and merit.

In setting up such a new department, not only to supervise the state mental hospital program but also to regulate local mental hygiene and health activities, Dr. Treadway suggested the establishment of a bipartisan state board similar to the regents of the University of California or the State Board of Health. He would have the terms staggered so that no change of state administration would upset the board's functioning.

Among the factors needed for a better mental health program. Dr. Treadway listed an enlightened medical profession, sound public policies including proper financial support and effective administration of the mental institutions, and the dissemination of data on mental illnesses and their causes which would produce an informed and articulate public opinion on the subject.

The federal health service official also discussed the need for child guidance clinics for early recognition and treatment of mental illnesses, establishment of special educational facilities for defective youngsters, emphasis on research into causes and treatment of mental maladies and revision of what he termed the present archaic state law on insanity commitments.

Although $200,000,000 is being spent annually in the United States for the care of the mentally ill, he said, less than 1 per cent goes for research purposes.

There are as many beds required in the establishments for the care of the mentally ill in America, he reported, as there are for all other forms of disease. And, in recent years, he added, 14,000 new beds have been needed in mental institutions annually.

The conference was informed that out of every 22 children born in this country, one finds his way into a mental hospital and one other seeks mental health assistance but does not reach an institution.

COMMITTEE ON HISTORY

Re: History of the Alameda County Association

Dr. Milton Shutes, historian of the Alameda County Medical Association, in the October 16th issue of the Association's *Bulletin* gives the following interesting data:

The first Alameda County Medical Association, consisting of nine members, met twice in the new Court House in San Leandro on August 18 and 25, 1860. It was the first of its kind in the State. Although it organized itself properly and set a date for its third meeting early in October, it promptly disintegrated, presumably in the political tumult that ushered in the Civil War.

Nine years later, eight other men from acceptable medical schools, seeking the distinction and stimulation of organization, met to form the Oakland Medical Association. In the act of incorporation, however, the name was changed to the Alameda County Medical Association. The rules and medical ethics of the American Medical Association were adopted, a library was begun, meetings were held once a month in the "reception parlors" of members, and within a year the membership had doubled itself. It was the third county society in the State to get organized, preceded by one year only by the Sacramento and San Francisco County Medical Associations in 1868. It was inspired by men such as Dr. Thomas H. Pinkerton and further vitalized by men such as the famous Le Conte brothers.

Through the remaining thirty years of the 19th century, as oak trees gave place to city streets, the growing membership of the Association fermented with the leaven of scientific medicine. The microscope became something more than of academic interest; the tenaciously held theory of zymosis gradually gave place to microscopic organisms as the causes of infectious diseases; and the art of abdominal surgery passed from hesitant beginnings to its firm foundation. In addition to its primary interest in medicine, it spent much of its energy in fighting medical charlatans, "irregular and ignorant medical men," and with a certain naïveté against the ancient evils of society—prostitution and alcoholism.

The last fifty years and more of this Society lies within the memory of some present men. They are living witnesses to the momentum begun seventy-five years ago that has carried the Alameda County Medical Association to its present numerical, financial, organizational and scientific strength, and to its leadership in an acceptable approach to "social medicine."

Medical History: In Los Angeles County

The *Bulletin* of the Los Angeles County Medical Association in its October 5 issue printed the following:

WILL YOU HELP US OBTAIN PICTURES OF FORMER OFFICERS

The Library of the Los Angeles County Medical Association is very desirous of completing its file of portraits of past officers of the Association. Photographs of a number of members who years ago held office are missing from the files or were never received in those early days.

If you should happen to have a picture of any type or know where one can be obtained of any one of the following physicians, please get in touch with the office of the secretary, 1925 Wilshire Boulevard:

L. L. Dorr	Secretary	1871
R. H. Dalton	President	1876
Charles C. Barton	Secretary	1877
W. Lockhart	President	1880
H. B. Lathrop	Secretary	1882
W. G. Cochran	Secretary	1883
W. L. Wills	Secretary	1885
F. A. Seymour	President	1885
A. McFarland	President	1886
E. T. Shoemaker	Secretary	1886
F. T. Bicknell	President	1887
W. D. Babcock	Secretary	1888
G. W. Lasher	President	1888
J. H. Davidson	President	1890
M. L. Moore	President	1891
W. W. Hitchcock	President	1892
D. G. MacGowan	President	1894
O. D. Fitzgerald	President	1895
E. A. Praeger	President	1898
D. L. McCarthy	Secretary	1900
C. G. Stivers	Secretary	1901
J. H. Utley	President	1902
W. W. Beckett	President	1904
Joseph M. King	President	1905
F. C. E. Mattison	President	1906
S. P. Black	President	1909
W. W. Richardson	President	1910
William M. Lewis	President	1913
Charles Whitman	President	1916
William Duffield	President	1918
W. T. McArthur	President	1919
Rea Smith	President	1920
Walter Brem	President	1921
George G. Hunter	President	1929

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (63)

Alameda County (1)

Edwards, Robert L., *Oakland*

Butte-Glenn County (1)

Horning, Merritt C., *Chico*

Los Angeles County (43)

Appelbaum, Alfred, *Huntington Park*
Barmaneder, Anton, *Los Angeles*
Bartosh, Esther H., *Los Angeles*
Beauchamp, M. L., *Memphis, Tennessee*
Berez, Joseph S., *Redondo Beach*
Blinstrub, A. A., *Inglewood*
Chavannes, V. Cecile, *Culver City*
Coleman, Ralph Leslie, *Los Angeles*
Covey, Herman W., *Los Angeles*
Cummings, Clara Mae, *Burbank*
Dale, Charles L., *Los Angeles*
Dalton, Burr, *North Hollywood*
Daniele, Joseph A., *Los Angeles*
Demandante, Primitiva D., *San Pedro*
Donahey, Victor V., *Studio City*
Drummond, Donald L., *Los Angeles*
Edmunds, Joseph T., *Alhambra*
Finesilver, Benjamin, *Beverly Hills*
Gaster, Joseph, *Los Angeles*
Griffin, Edna L., *Pasadena*
Ham, George H., *Meridian, Mississippi*
Hill, Wilbert G., *Los Angeles*
Hirshberg, H. A., *Camp Roberts*
Hofgaarden, Luther V., *Los Angeles*
Kerrick, Stanley Edward, *Los Angeles*
Knutti, Ralph E., *Los Angeles*
Kurlander, Joseph J., *Los Angeles*
Levan, Norman E., *San Francisco*
McGinnis, James Edward, *Los Angeles*
Michael, Ralph H., Jr., *Los Angeles*
Murray, Leo Charles, *Los Angeles*
Myers, R. B. S., *Santa Monica*
Nielsen, John W., *Los Angeles*
Paskan, Julius A., *Culver City*
Penner, O. W. J., *Temple City*
Rosenthal, Samuel M., *Los Angeles*
Schiff, Isadore Joseph, *Los Angeles*
Sharpe, Walter Eugene, Jr., *San Pedro*
Shmukler, B. Cecelia, *Los Angeles*
Sturges, Evleyn P., *Los Angeles*
Sugarman, Jerome N., *Los Angeles*
Welton, Walter F., *South Gate*
Wilmoth, Marion E., *San Pedro*

San Francisco County (13)

Abrams, Alan L., *San Francisco*
Erler, Theodore G., Jr., *Los Angeles*
Fung, Paul F., *San Francisco*
MacLaggan, James C., *San Francisco*
Sanderson, Herbert C., *San Francisco*
Thornton, Elizabeth, *San Francisco*
Torre, Walter N., *San Francisco*
Ury, Oskar, *San Francisco*
Walsh, John D., *San Francisco*
Warner, George F., *San Francisco*
Weber, Manuel L., *San Francisco*
Windholz, Frank S., *San Francisco*
Woolley, Le Grand G., *San Francisco*

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

San Joaquin County (4)

Clarke, Robert W., *Murphys*
Johnson, Carrol Allen, Jr., *Stockton*
Richli, William Campbell, *Stockton*
Zeller, Robert F., *Stockton*

Stanislaus County (1)

Davis, J. Paul, Jr., *Turlock*

Transfers (1)

Nelson, Clarence E., from San Diego County to Los Angeles County.

In Memoriam

Alanson, Milton R. Died at San Francisco, August 16, 1944, age 60. Graduate of the Cooper Medical College, San Francisco, 1907. Licensed in California in 1907. Doctor Alanson was a mmeber of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Cunningham, Robert Law. Died at Los Angeles, September 10, 1944, age 63. Graduate of the Johns Hopkins University School of Medicine, Baltimore, 1907. Licensed in California in 1909. Doctor Cunningham was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Johnson, Milbank. Died at Pasadena, October 3, 1944, age 72. Graduate of Northwest University Medical School, Chicago, 1893. Licensed in California in 1893. Doctor Johnson was a member of the Los Angeles County Medical Association, and the California Medical Association.

◆

Litle, Elmer William. Died at Los Angeles, September 8, 1944, age 74. Graduate of the Grand Rapids Medical College, Michigan, 1901. Licensed in California in 1921. Doctor Litle was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Preston-Brown, Frances M. Died at Los Angeles, August 18, 1944, age 40. Graduate of the Woman's Medical College of Philadelphia, Pennsylvania, 1941. Licensed in California in 1944. Doctor Preston-Brown was a member of the Los Angeles County Medical Association, and the California Medical Association.

◆

Smith, Mark Harrison. Died at Glendale, September 8, 1944, age 73. Graduate of the State University of Iowa College of Homeopathic Medicine, Iowa City, 1895. Licensed in California in 1925. Doctor Smith was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Waddell, William Everett. Died at Los Angeles, September 1, 1944, age 74. Graduate of Pulte Medical College, Cincinnati, Ohio, 1887. Licensed in California in 1895. Doctor Waddell was a Retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

CALIFORNIA PHYSICIANS' SERVICE[†]

Board of Trustees

Ray Layman Wilbur, M.D., President, Stanford University
Glenn Myers, M.D., Vice-President, Los Angeles
Fletcher B. Taylor, M.D., Vice-President, Oakland
T. Henshaw Kelly, M.D., Secretary, San Francisco
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C.P.S. Beneficiary Members

	August 1943	*August 1944*
Commercial Program	49,000	86,000
Rural Health Program	2,400	2,011
War Housing Program	36,347	15,464
Total Membership	87,747	103,475

* * *

During the current month of October, California Physicians' Service is in the process of enrolling over 20,000 new members. This is over twice the number that were enrolled in any other single month. It is doubtful that this rate of growth can be maintained in the succeeding months, since one large group contributed considerably to this number. Nevertheless, it is an indication that C.P.S. is becoming more and more acceptable to the public, and especially through the larger industries. It is also an indication that labor, in the masses, are looking favorably upon C.P.S. as a medium through which they may prepay their medical care.

As an indication of some of the healthy public relations aspects of C.P.S., it is of interest to note that since the May meeting of the California Medical Association, some 200 physicians have become new professional members of C.P.S., and the roster is growing all the time. Aside from the final recommendation by the medical profession as a whole that C.P.S. should be backed, individual County Societies are now coöperating in canvassing their membership for those physicians who, for one reason or another, did not see fit to join up in the beginning. Also, new physicians coming into the communities are contacted, and the combination of these two will result in a steady increase in professional membership which is evident in this office to date.

A. E. Larsen, M.D.
Executive Medical Director.

Huntington's Chorea.—The entire medical career of George Huntington was devoted to work as a medical practitioner. He modestly disclaimed the one scientific study that he had ever made, saying that the credit for recognition of the choreic condition he described was due his father and grandfather who had familiarized him with this infrequently seen familial disease. The fact remains, however, that scientific study of this disease was based on his classical description written in 1872.—Warner's *Calendar of Medical History.*

[†] Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session will be held in New York City.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In November, KFAC will present these broadcasts on the following Saturdays: November 4, 11, 18 and 25.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Departments of the United States Army and the United States Navy, are on the air each Saturday at 1:30 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Historical:* On Dec. 11, 1844, Horace Wells of Hartford, former dental partner of W. T. G. Morton, had a tooth extracted without pain by Dr. John Riggs, using N_2O prepared by G. Q. Colton; appropriate for the centennial is the well illustrated "Life and Letters of Horace Wells," by W. H. Archer (*J. Amer. Coll. Dentists,* 11:81-210, 1944). Preview of J. B. deC. M. Saunders and C. D. O'Malley's translation of the Vesalius *Fabrica* (1543) appears (*Ibid.,* 211-218). Their translation and annotation of the *China Root* (1546) should appear soon. F. J. Cole offers a *History of Comparative Anatomy from Aristotle in 18th Century* (Macmillan, London, 1944). H. Bailey and W. J. Bishop publish well illustrated *Notable Names in Medicine and Surgery* (H. K. Lewis, London, 1944). I. Gladston discusses Descartes and modern psychiatric thought (*Isis,* 35:118, 1944). J. W. Wilson reviews cellular tissue and the dawn of the cell theory (*Ibid.,* 168). Why not buy some of the classics of medicine, as suggested so wistfully by H. Sigerist (*Bull. Hist. Med.,* 16:1, 1944)? Congratulations to *La Juventud Medica* of Guatemala on its semicentennial.

2. *Blood Substitutes:* F. S. Robscheit-Robbins & Co. discuss usefulness and toxicity of gelatine as a plasma protein substitute (*J. Exp. Med.,* 80:145, 1944). A Wormall discusses the nonantigenicity of gelatine (*Nature,* 154:332, Sept. 9, 1944). G. Riedel and K. Zipf suggest "periston" (2½ per cent polyvinyl-pyrrolidon in buffered Ringer's sol.) IV as useful blood substitute in hemorrhagic shock (*Arch. Exp. Path. Pharmak.,* 203:25, 1944).

3. *Chemotherapy:* P. Ellinger & Co. find sulfonamide sterilization of gut interferes with production of nicotinamide by intestinal flora, possibly causing deficiency symptoms (*Nature,* 154, 270, Aug. 26, 1944). J. Ohnysty and W. D. Wolfson recommend 10 Gms. potassium bicarbonate daily as adjunct to sulfonamide therapy in pneumonia complicating cardiac decompensation (*New Eng. J. Med.,* 231:381, Sept. 14, 1944). M. A. Schnither and C. C. Lenhoff report that 30 Gms. urea daily with sulfonamides will break most sulfonamide resistance in gonorrhea (*J. Lab. Clin. Med.,* 29:889, 1944).

4. *Antibiotics:* H. W. Florey & Co. offer brief symposium on penicillin (*Brit. Med. J.,* 2:169-179, Aug. 5, 1944). O. Roberts and D. Murphy recommend penicillin agar for local application to infected areas (*Irish J. Med Sci.,* 6th ser., *223*:225, 1944). I. W. J. McAdan & Co., suggest 3-hour IM inj. of 25,000 units in 2 c.c. for emergency or ambulatory patients,—otherwise continuous IM infusion 100,000 units in 100 c.c. per day (*Lancet,* 2:336, Sept. 9, 1944). J. Unger describes penicillinase from B. subtilis (*Nature,* 154:236, Aug. 19, 1944).

5. *Books:* T. H. Howell offers *Old Age: Practical Points in Geriatrics* (H. K. Lewis, London, 1944). G. Draper & Co. issue *Human Constitution in Clinical Medicine* (P. B. Hoeber, N. Y., 1944). F. W. Jones follows his fine *Principles of Anatomy as Seen in the Hand* with his equally important *Structure and Function*

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† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

as Seen in the Foot (Bailliere, Tindall and Cox, London, 1944). D. Hunter's 1942 Croonian Lectures on *Industrial Toxicology* finally appear (Oxford Press, 1944). S. C. Shanks edits 3 vol. *Textbook of X-Ray Diagnosis* (H. K. Lewis, London, 1944). R. R. Foote presents *Varicose Veins, Hemorrhoids and Other Conditions: Their Treatment by Injection* (H. K. Lewis, London, 1944). S. F. Markham discusses *Climate and the Energy of Nations* (Oxford Press, 1944). W. N. Bispham describes *Malaria: Its Diagnosis, Treatment and Prophylaxis* (Wms. and Wilkins, Balt., 1944). A. A. Brill notes Freud's Contribution to Psychiatry (Norton, N. Y., 1944).

6. *Otherwise:* J. O. Parnas makes fine review of biologic catalysis (*Amer. Rev. Soviet Med.*, 1:485, 1944). P. D. Lamson thinks "biotrepy" is the golden egged goose (*Sci. Monthly*, 59:215, 1944). J. P. Greenstein & Co. begin important chemical study of human cancer (*J. Nat. Cancer Inst.*, 5:55, 1944). W. F. Freidewald and P. Rous survey initiating and promoting elements in tumor production (*J. Exp. Med.*, 80:101, 1944). H. C. de Souza-Araujo prepares leprosy antigens ("leprolins") for diagnosis and treatment (*Mem. Inst. Oswaldo Cruz*, 39:349, 1943: 40:101, 1944). Note excellent symposium on peripheral vascular disorders, low temperature injury, and traumatic arterial spasm (*Brit. Med.* Bull., 2:136, 1944). E. J. Carey continues fine work on secretion of motor end-plates, showing polio effects (*Amer. J. Path.*, 20:961, 1944).

Los Angeles Heart Association.—The Los Angeles Heart Association announces its 14th Annual Postgraduate Symposium December 6-7, 1944.

Guest Speakers: Arthur C. DeGraff, M.D., Samuel A. Brown, Professor of Therapy and Chief of Cardiac Clinic, New York University, College of Medicine; also Captain William H. Leake, Lt. Commander George Griffith, Lt. Commander Robert Huntington, and Lieutenant Hugh Butt of the U. S. Naval Hospital, Corona, California.

Programs and registration blanks will be mailed about November first by William Paul Thompson, M.D., Program Chairman.

Panel Discussion on the Future of Medicine.—The Medical Society of the District of Columbia, on October 7, 1944, in Washington, D. C., presented a panel discussion on "The Future of Medicine," participated in by John P. Peters, M.D., of Yale University; Harvey Bartle, M.D., of the Pennsylvania Railroad; Vice Admiral Ross T. McIntire, Surgeon General of the U. S. Navy; Thomas Parran, M.D., Surgeon General of the U. S. Public Health Service; and John H. Fitzgibbon, M.D., Chairman, Council on Medical Service and Public Relations of the American Medical Association.

These articles will probably appear in the Official Journal of the Medical Society of the District of Columbia.

The address of John H. Fitzgibbon, M.D., of Portland, Oregon, present Chairman of the A.M.A. Council on Medical Service and Public Relations, was of special interest. Reference is made thereto in Press Clippings department in this issue of CALIFORNIA AND WESTERN MEDICINE.

British Find Beveridge Plan Not Unalterable.—The Churchill government has pigeonholed the Beveridge Plan for British "social security" and devised a substitute which, while it retains "cradle to the grave" insurance, lowers considerably both the contributions of the insured and the benefits to be paid them.

The news will come as a shock to the "social planners" in this country who have held up the Beveridge Plan as the criterion for American legislation, and insisted that the movement for extreme regimentation is growing in force in England and that this country must follow suit.

While too many conclusions cannot be drawn from the insufficient evidence at hand, it seems likely that the modification of the plan indicates that sentiment for regimentation in England is getting weaker instead of stronger.

Honors to Dr. J. C. Geiger, Director of Public Health, City and County of San Francisco.—On August 23, 1944, the Faculty of Medicine, the University Senate and the Board of Administrators of Tulane University of Louisiana, requested Dr. J. C. Geiger to make the Commencement address at its largest Commencements ever to be held, on October 14, 1944, in New Orleans, Louisiana.

At that time the honorary degree of Doctor of Science was conferred upon him, this being his second honorary degree to be so received from this University. The current citation is as follows:

"A noted epidemiologist, a medical officer of health and author of excellence, and Tulane's most distinguished alumnus."

Honors from Peru.—His Excellency, the President of Peru, recently bestowed upon Dr. J. C. Geiger the Decoration of the Heraldic Order El Sol Del Peru in the class of Knight Commander. The citation follows:

"As President of the San Francisco Chapter, Pan American Society, Dr. J. C. Geiger has aided materially in fostering and cementing friendly relations between countries of the Americas; as a teacher of preventive medicine and public health in universities, medical officer of health and chief of hospitals, he has added much to the glorious chapter of the prevention of disease."

The Order of the Sun of Peru was founded in 1821 by the great liberator, San Martin, and is the oldest in Latin America.

"Urology Award.—The American Urological Association offers an annual award 'not to exceed $500' for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the Secretary, for full particulars.

"The selected essay (or essays) will appear on the program of the forthcoming June meeting of the American Urological Association.

"Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1945."

Lack of Salt May Be Cause of Poliomyelitis.—Lack of sufficient salt in the body may be one of the factors that predispose a child to poliomyelitis, according to Dr. James F. Rinehart, professor of pathology in the Medical School on the San Francisco campus of the University of California.

The facts that infantile paralysis epidemics always come in the summer months when copious perspiration removes salt from the system, and that active, robust children are more likely to be stricken, suggest that salt depletion may be one of the causes of susceptibility, Dr.

Rinehart points out. Likewise the disease seems to attack those children who recently have been physically overactive.

Studies of 30 patients by Dr. Rinehart during a recent epidemic revealed that the whole blood chloride concentrations were generally lowered, and the spinal fluid concentrations were moderately lowered. The cell volumes were increased, which might indicate that the depletion of salt in the serum caused a flow into the blood cells.

Further clinical studies as well as animal investigations were recommended by Dr. Rinehart. He also suggested that in the meantime children should be given plenty of salt in the summer months to make up for the large amounts excreted by the body in perspiration.

New Lamp Treatment Extends Activation Period of Vaccines.—A newly developed ultra-violet lamp which kills or inactivates bacteria and viruses in less than one second may revolutionize the production of vaccines according to five Chicago physicians.

They report that the new method kills or inactivates bacteria and viruses in a fraction of a second by exposing continuously flowing films, less than 1 millimeter in depth, to the rays of the lamp.

With this method there is a minimum loss of antigenicity, or ability to produce antibodies when the vaccine is introduced into the body, the *Journal* said, and explained there is undue destruction of antigenic properties in the usual method of inactivation with heat or chemicals.

Experiments indicated that vaccines prepared with the new method retain their strength for longer periods, and irradiated rabies vaccines showed no loss of potency after having been stored for six months at icebox temperature. Phenolized vaccines deteriorate rapidly when stored at these temperatures, the magazine declared.

The vaccines were tested on animals by Dr. Sidney O. Levinson, Albert Milzer, Howard J. Shaughnessy, John L. Neal and Franz Oppenheimer, working at Michael Reese Hospital and the Division of Laboratories, Illinois Department of Health.

Special Health Magazine.—The August (1944) issue of *The Railroad Journal* is a special number devoted to American Health. Considerable time and effort have been spent in assembling the interesting and valuable material appearing in this issue and the contents should be of interest to physicians. Copies have been placed on file in the Lane, U. C. and Los Angeles medical libraries. The National Physicians Committee was instrumental in suggesting this special issue to the Editors.

Seventh Annual Forum on Allergy.—The Seventh Annual Forum on Allergy will be held in the Hotel William Penn, Pittsburgh, Pennsylvania, on Saturday and Sunday, January 20-21, 1945. This is a meeting to which all reputable physicians are most welcome, and where they are offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive postgraduate instruction.

This international postgraduate society was founded in 1938 at Cincinnati, Ohio, to provide a place in which to review the progress of clinical allergy, to provide in peace times a *Forum* for the younger members, and to offer intensive postgraduate instruction in allergy to physicians working in other fields.

In 1940 the name was changed to correspond to the international character of its attendance and the *Forum's Gold Medal* and annual oration were established as a means of recognizing outstanding contributions to clinical allergy.

This year the Marcelle prize has been established and will be given to the authors of the best papers on Allergy appearing in the American medical literature during the year. The first prize will be for three hundred and fifty dollars and the second prize for one hundred and fifty dollars. The awards will be based on the decision of a jury of distinguished allergists.

For further information, copies of the book and registration, write Jonathan Forman, M.D., Director, 956 Bryden Road, Columbus 5, Ohio.

$400,000 Health Aid.—Control and eradication of tuberculosis is a major health problem facing the nation, Dr. Wilton L. Halverson, State director of public health, told northern California health officers' meeting on October 19 in the State Building, San Francisco, to map a postwar health program.

Dr. Halverson said California was scheduled to receive approximately $400,000 of a $10,000,000 fund set up by Congress to fight tuberculosis, and he urged the delegates to coöperate by seeking out tuberculosis victims, isolating them, and utilizing all available means to fight the disease.

University of Texas Medical School: Dr. Chauncey D. Leake, Dean.—In its issue of September, the *Texas State Journal of Medicine*, prints the following:

Medical Branch Texas State University Again in Spotlight.—In a report to the Board of Regents of the State University, President Dr. Rainey recently raised the question as to whether the Medical Branch of the University should be removed from Galveston to some other center in the State. He recommended such removal, and to Austin, where it could be merged with the Main University. While the question is of course a highly controversial one, and certainly the *Journal* can hardly voice an opinion in the matter unless and until the Association formally sets up a policy with regard thereto, however, the situation is of such importance that it should receive the attention of the medical profession of the State. . . .

Dr. Chauncey D. Leake, Dean of the Medical Branch of the University, is not in favor of the proposal of Dr. Rainey that the school be removed to Austin or anywhere else. He submits the following facts pertaining to the Medical Branch:

"1. Value: Land, buildings, equipment, carried at cost as of August 31, 1944, at $4,463,346.64, not counting State Psychopathic Hospital nor Stewart Convalescent Home.

"2. Standing: Medical School fully approved by Council on Medical Education and Hospitals of American Medical Association and by Association of American Medical Colleges; Nursing School fully approved by State Board of Nurse Examiners, only accrediting agency recognized by American Medical Association; John Sealy Hospital, one of only seven Texas hospitals approved by American College of Surgeons, and by Council on Medical Education and Hospitals of American Medical Association for interne and resident training, and whose nursing training is approved by State Board of Nurse Examiners; Curricula for medical laboratory technicians and physiotherapists approved by Council on Medical Education and Hospitals, American Medical Association.

"3. Staff: Need 200 teachers (1 per 10 students per course, with 20 major courses and 100 students per course), have 174; had 158 in 1943; 86 in 1939. Clinical teachers now 66, with 33 on 'full-time,' not engaged in private practice. In military service, 18. . . .

'4. Clinical Material: Need at least 5 beds per clinical student, or 1,000 bed hospital. Have 420 bed hospital (State Psychopathic Hospital, 100 beds, closed). For fiscal year ending September 1, 1943, had 2,365 Galveston charity patients, for 32,953 patient-days; 3,001 state referred charity patients, for 64,055 patient-days; 3,988 pay patients, for 52,654 patient days, at average patient-day cost of $4.90; 1,275 state referred patients were admitted through diagnostic clinic on physicians' requests from 124 counties in the state (balance from state agencies). State appropriation for year for hospital was $391,000. Waiting list daily over 60. With more beds and more support many more patients could be handled. Outpatient visits to the Clinic totaled 101,432 for the year, or about 300 per operating day.

"5. Sealy and Smith Foundation: Charted solely for support of John Sealy Hospital; operates with regents $700,000 trust fund; has potential assets over $15,000,000. Now offers University $1,500,000 for erection of general hospital, planned in 1939, to provide needed beds. . . .

"6. Health Program: For benefit of people of state, to utilize for health education and research, suitable health facilities wherever they may exist in the state. Implied is coördination of Medical School, Nursing School, and technicians curricula at Medical Branch, Galveston, for undergraduate and postgraduate teaching and research, with preceptorial centers for such efforts. . . .

The following resolution pertaining to the Medical Branch of the University, recently prepared by the Medical Committee of the Board of Regents, was adopted by the Board:

"We, your Medical Committee, recommend that the Board of Regents of the University of Texas express to the staff and faculty of the Medical Branch our sincere appreciation and our full and complete confidence for the successful organization, coöperation and accomplishments that have been done and performed by those directly responsible for the conduct and operation of the Medical School since it has been under the supervision and control of Dr. Leake. The administration of the Medical School has had and now has the complete coöperation of and the unified efforts of every department and faculty member of said Medical School as well as the very generous coöperation and confidence of the Sealy-Smith Foundation which has for many years been the principal benefactor of the Medical Branch, without which the school in the past could not have been successfully conducted." . . .

San Francisco Health Survey to Start in 30 Days.—Before November, experts of the American Public Health Association will conduct a survey here of the city's Health Department.

The checkup, according to Chief Administrative Officer Brooks, is expected to bring answers to many questions, including these:

1. Is the city getting its money's worth?
2. Should the department of public health be independent?
3. Are existing facilities adequate and being used to best advantage?
4. Are city hospitals concentrating too much on training young doctors and too little on care of indigents?
5. Are taxpayers paying too much for scientific experiments in the guise of care for indigents?
6. Are there too many part time doctors on payrolls?
7. Have recently inaugurated consolidation of health inspection services gone too far or not far enough?

Brooks explained that no one health department is under fire.

Child Clinics Make Medical Affiliations.—Closer affiliation of child guidance clinics with medical institutions such as hospitals, psychiatric hospitals, and medical schools, is one of the recent trends in child psychiatry, according to Dr. Karl M. Bowman, professor of psychiatry on the San Francisco campus of the University of California.

In many cases child psychiatry can be done best in a medical atmosphere rather than in one that is educational. For instance, psychiatric clinics for children attached too closely to the school system often suffer political pressure; likewise some problems of children, such as sex, are better handled in a hospital setting, Dr. Bowman says.

Psychiatric wards for children in many parts of the country have been built, but often have remained idle because of insufficient funds for operation. This is a great waste because there is need of further study of the psychiatric problems of children, particularly in linking up the relationship between the simple behavior problems of children with the early signs of serious types of mental disorders, Dr. Bowman indicates.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Nobel Prizes in Medicine to Three Americans

Year's Award Made for Study in Nerve Functions; Sandburg Mentioned as Likely Winner

Stockholm, Oct. 26.—(A.P.)—Award of Nobel prizes in medicine to four scientists now in the United States, three of them Americans, was announced tonight by the Nobel Foundation.

The 1944 award, covering work in both physiology and medicine, went to Joseph Erlanger, professor of physiology at Washington University, St. Louis, and Herbert Spencer Gasser of New York, director of the Rockefeller Institute, for their studies of the different functions of the individual nerve threads.

The 1943 award, being made after a year's delay, was shared by Edward Adelbert Doisy, professor of biochemistry in the St. Louis (Mo.) University School of Medicine, and Henrik Dam of Copenhagen, now at Strong Memorial Hospital, Rochester, N. Y.

The prize for 1943 was for the discovery of the chemical nature of the "K" vitamin.

The 1944 award for medicine is worth 121,841 kroner ($29,059.08), which will be divided between the two winners. The 1943 prize is worth 123,690 kroner ($29,500.07) and also will be divided by the winners.

Two prizes also may be awarded this year in physics, two in chemistry and one in literature. If an award for literature is made, it probably will be announced November 9. Two persons who have been mentioned as possible winners are Johnnes V. Jensen, Danish author of "The Long Journey," and Carl Sandburg, the American poet. There will be no award for peace this year.

Announcements of the winners of each of the prizes is made separately by the academies which make the selections. The winners in medicine were chosen by the Caroline Medical Institute in Stockholm.—San Francisco *Examiner*, October 27

Service Physicians Count on You

. . . In explaining the disinclination of some members to serve on committees, one of our doctors said a short time ago that not a few of his colleagues were critical of organized medicine on a national level because it had gained public ill will and was doing nothing to put itself in a more favorable light. In this respect, he said, it had failed in its obligations to its membership.

Well, this might be argued pro and con. But the fact remains that organized medicine is made up of medical societies and they, in turn, are made up of individuals. Each has a job to do. All have spheres of influence. None can escape responsibility for whatever happens to medicine.

So let it not be said of our Medical Society or of us as individuals that according to our abilities we failed to interest ourselves in the welfare of the people and the medical profession. This is a duty we owe not only to ourselves and our Society but to our men in the services, who are unable to perform the functions which they would in normal times. We must not let them down.—President's Page in *Medical Annals of District of Columbia.*

Richmond Unions Seek More Doctors for War Workers

Richmond, Aug. 31.—Absenteeism and lowered morale among war workers were the main targets of a meeting recently called by the Bay Area Joint Labor Health Council. The confab brought together representatives of the CIO, AFL, government and medical profession.

The meeting was stimulated by the lead of a highly successful meeting called two weeks ago by the San Pedro Labor Health Committee, and heard experiences of rank and file members of the Joint Health Council's constituent unions in securing medical care.

Stories painted a picture of long waits in doctors' offices, futile efforts to get essential home visits and other aspect of the general deterioration of medical service and its resultant reflection in absenteeism.

Dr. Harold Fletcher, chairman of state Physicians Procurement and Assignment said that this agency had estimated seven months ago that a minnium of from eight to 10 additional physicians were needed in Richmond if the ratio of doctors to the population were to be raised from 1 to 5,000 to a safer proportion.

Dr. Fletcher said as a result of joint effort on part of the state medical association and California Physicians' Service, an emergency medical center with one full time physician was established, but noted a lack of publicity added to the inadequacy of the service.

Sec. Roy Sturtevant, Contra Costa CIO Council urged all unions to publicize the project.

While no question existed as to the need for more doctors in the Richmond area, Dr. Fletcher said his organization was at a loss as to where to get additional forces.

He said the agency has no authority to control the movement of physicians from an area of abundance to one of scarcity.

Saul Wachter, member of the AFL Technical Engineers' Local 489, declared the shortage could be eliminated by the granting of funds and authority to the U. S. Public Health Service to commission doctors for medical care purposes in areas of need.—San Francisco *Labor-Herald*, September 1.

Medical Center Treated 389 at Monthly Clinic

Relieving to some extent the shortage of medical aid in this community, the Medical Center at 4800 Cutting boulevard last month treated 389 cases in its clinic and the two doctors on duty made 138 house calls.

The registration of 416 patients during August indicates that residents of Richmond are becoming aware of the facilities of the organization when it is considered that only 34 patients made use of the Center's service during its first month of operation in May.

The Medical Center was opened then under the sponsorship of the California Medical Association and has been administered by the California Physicians' Service. The Center was opened following a survey by the State Physicians' Service which showed the deplorable discrepancy between the number of doctors and the population here.

The Center is open 24 hours a day with a doctor on duty at all times. During the day Elodie Hogan, a registered nurse, is in charge.

In August flu was the predominant disease treated, with 107 cases cared for by the Medical Center. Next in number were cases of skin infection, numbering 70. Fifty-five cases of cuts, bruises and minor injuries were treated, and 33 cases of communicable diseases, mainly measles and whooping cough, were attended.—Richmond *Independent*, September 12.

Physicians' Service Plan Outlined by Physician

Meeting with Mrs. J. F. Roberts, president of the Women's Auxiliary, Humboldt County Medical society, the group heard an interesting talk by Dr. J. S. Woolford, who discussed and explained the California Physicians' Service..

Dr. Woolford explained that advances in medical education during 40-year period have resulted in fewer doctors and have caused increases in the cost of medical care. One of the first surveys on the cost of medical care was made by Dr. Ray Lyman Wilbur when he was Secretary of the Interior. After the survey Dr. Wlibur was instrumental in forming the California Physicians' Service, a prepaid medical plan provided hy doctors for low and middle-income groups, according to the speaker.

This medical service, Dr. Woolford said, is now available to Humboldt people and additional information may be obtained by calling 2727. The plan offers the individual unrestricted choice of physicians and hospitals.

The auxiliary conducted a business session after which they enjoyed refreshments and a social hour. Others present were Mrs. Max Todd, Mrs. Allen Watson, Mrs. Carl Mathewson, Mrs. W. J. Quinn, Mrs. Lawrence Wing, Mrs. Darrel Broderick, Mrs. Joseph F. Walsh, Mrs. Nathan Wasserman.—Eureka *Standard*, October 6.

Health Program to Be Pressed

Plans were recently made at a meeting of the Coördinating Health Council of the Vallejo Housing Projects to put a long-delayed public health program into operation, according to an announcement made by Dr. H. R. Quinney, chairman of the Vallejo Housing Authority.

The meeting which was held in the Victory Auditorium, was attended by members of the Tenant and Health Committees of Chabot, Federal Terrace, Victory-Solano and Hillside Dormitories. Dr. Quinney presided.

The committee, originally formed to promote such a health program, has devoted most of its time during the past year to problems raised by the California Physicians' Service, but the recent formation of another group to handle the CPS work frees the health committee for its original purpose.

Others attending the meeting were Carmel McKay, education director of the Solano County Tuberculosis Asosciation, and Mrs. Lorraine Kaufman, health services advisor.—Vallejo *Standard*, Septmeber 14.

Osteopathic College of Los Angeles Grants Honorary Degrees

Six honorary degrees were awarded by the Los Angeles College of Osteopathic Physicians and Surgeons at its 48th annual commencement exercises when 53 students were graduated on October 4. The class went without vacations to complete the four-year course in three years.

Dr. John W. Harbeson, president of Pasadena Junior College, was awarded the honorary degree of Doctor of Humane Letters and Rabbi Edgar F. Magnin of Wilshire Boulevard Temple, who made the address to the graduates, the degree of Doctor of Humane Letters Others honored and the degrees presented were: Dr. Glen R. Philips, Doctor of Humane Letters; Florence M. Irish, Doctor of Humanics; Dr. Richard A. Sheppard of Cleveland, Ohio, president of the American College of Osteopathic Surgeons, Doctor of Science; Dr. Ernest Sisson of Oakland, pioneer of California osteopathic physicians, Doctor of Science.

Presentation of candidates was made by Dr. Earle L. Garrison, dean of the college, and degrees were conferred by Dr. W. Ballentine Henley, president of the college.—Los Angeles *Times*, October 4.

Columnist Chester Rowell on Social Security and Health Insurance

"Social progress in America did not begin in 1933."

The first great break toward social insurance came under President Theodore Roosevelt, whose proclamation in favor of workmen's compensation started the movement which secured its early adoption by most Republican States and few Democratic ones.

Other social security reforms were passed in Wisconsin under then Republican Governor Robert LaFollette, senior, and by Charles Evans Hughes, then Republican Governor of New York. The most comprehensive social program was that enunciated in the platform on which Hiram Johnson was elected Governor of California in 1910 and proposed in his inaugural address to the Legislature of 1911. And of all of them it was the only one practically completed the year it was proposed.

The railway labor act, old age and unemployment insurance and many other such measures were already laws, supported by both parties, long before 1933. And even the additional ones, adumbrated by Mr. Roosevelt in his Commonwealth Club speech in 1932, and in his inaugural address in 1933, did reflect what Mr. Dewey now calls a "climate" of confidence. But they were not in the platform on which he ran and was elected, all of which he repudiated after election, and they did propose certain measures, most of which did not work, while many of the others were found unconstitutional.

This is not to deny Mr. Rosevelt credit for this "climate," and such of his measures as time has approved. It is merely to question his claim to a monopoly of them and to the Hitlerlike fiction that history began with him. . . .

But now comes Dewey. . . . He proposes, not to "preserve" the Roosevelt reforms, but to go on from there to still more advanced ones. Some of these, as did Roosevelt, he may later find too ambitious to be put quickly into practice. But he has the "climate," and the people have confidence that somehow he will carry it out. And they are glad to find him specific and unafraid—the very thing his original backers did not dare, but also will not dare repudiate.

The one exception is public health. After all, Mr. Dewey is running as the nominee of the opposition, and it is his business to oppose. . . . The best organized of these groups are the medical doctors under the political leadership of Morris Fishbein. So Governor Dewey goes after them.

Doubtless Dewey knows better. If not, he will soon learn, whenever he tries to put into practice the Fishbein contradictions. The people want not less but more health insurance. But the Fishbeinites do not want that in the only way the doctors can be paid for it.

The administrative difficulties of extending the system to farm laborers, small farmers, small shops, domestic servants and the self-employed have already forced resort to other methods wherever tried. For these there must be "medical" and not merely "hospital" benefits, and the doctors must get their pay.

This does not make such indirections idealistically impeccable. But when before did a campaign stop only as short as this of perfection?

It is a part of American free speech for informed critics to point this out. So, if they like, may the Fishbeinites. But they have nowhere else to go—not to Roosevelt, certainly. . . .—San Franciso *Chronicle*, September 26.

The Western New York Medical Plan

Insurance for medical and hospital care is here to stay. Whether it remains on a voluntary basis, the real American way, or is made compulsory with regimentation both of the medical profession and the public depends largely on the way the Medical Profession is willing to participate in the present voluntary Plans. The time is short. The advocates of Federalized Medicine are very active and have many supporters, and we physicians need a united front to offset the very serious drive to make us political tools. There is danger not only in the Federal picture but also in the State. Look at what Mayor La Guardia is attempting to do in New York City, and the threats that are made if physicians will not coöperate.

Your Western New York Plan is showing a very healthy growth, but we must move faster. We physicians of Western New York must not fail in our duty to do all in our power to keep our plan successful. . . .

You are urged to read the editorial in the *New York State Journal of Medicine*.

Physicians of Western New York study your Medical Plan. Know its provisions. Tell your patients about it. Keep literature in regard to it in your waiting rooms and hospitals. Accept patient-members graciously and please send in your service notices and bills promptly.—*Bulletin Medical Society, County of Erie, and Buffalo Academy of Medicine*, September, 1944.

Kaiser Predicts 30 Million Jobs in Postwar Indusrty

NEW YORK, Oct. 17 (AP)—Henry J. Kaiser told the New York Herald Tribune forum tonight that by present indications there should be 30,000,000 post-war jobs in aircraft, automobile, construction, transportation and service industries alone.

Kaiser, shipbuilder, said he was convinced that 2,000,000 homes should be built for ownership or rental in the first year and a half after conversion.

General Eisenhower, in a message, urged Americans to recapture the "terrific unity" the Nation possessed after Pearl Harbor.

Kaiser urged construction of modern hospitals in 1000 communities in the first year after the war.

Kaiser also told the forum that the cost of health service "well within the reach of all" might be "incorporated in the monthly payments" on homes.

General Eisenhower's message was read by Colonel Warren J. Clear, General Staff Corps. It said the United Nations forces "are opposed by an enemy battling with utter desperation," and added "there will be bitter fighting ahead."

Bernard M. Baruch, special adviser to the director of war mobilization, told the forum that "peace can be just about what America makes it," and that world security would be attained "if we provide jobs for all."—San Francisco *Chronicle*, October 18.

Medical Aid Not Sought on Health Appointment

Placer County Supervisors have instructed that a letter be written to Dr. Robert A. Peers, secretary of Placer, Nevada and Sierra County Medical Society, the proposal a committee of three doctors be appointed to discuss appointment of a health officer in Placer County is "not agreeable to the board."

The board took the position it would consider any man recommended by the Medical Society of Placer County for appointment as health officer, but that it would not deal directly with the committee appointed by the society.—Sacramento *Union*, October 11.

Dr. Herbert True, Ill, Is Taken to Home in Sacramento

Dr. Herbert F. True, Sacramento health officer, who was stricken with a serious illnes while vacationing in Santa Cruz early this month, was taken to his home on September 25.

His condition is reported to be improved, although he is not permitted to have visitors at this time.

City Manager Elton B. Sherwin has granted Dr. True a three month leave of absence. During his absence, Dr. W. W. Cress, chief of the emergency hospital staff, will serve as city health officer.—Sacramento *Bee*, September 26.

Intern Doctor Writes Medical Men's Music History

"The science of medicine is not one which confines its students to the study of anatomy and bodily ills—instead many noted physicians have laid down their scalpels and picked up batons or composer's pens."

So concluded Dr. Willard Lee Marmelzat, 25-year-old Los Angeles Queen of the Angels Hospital intern, who has been awarded the William Osler Medal, symbolic of the most outstanding annual contribution made in the field of medical history.

Begun while he was a student at Tulane University Medical School where he was graduated last February, the 30,000-word monograph which Dr. Marmelzat has entitled "The Musical Sons of Aesculapius," is expected to be published soon.—Los Angeles *Times*, October 14.

Dr. Rohrbacher to Reopen Office in Stockton

Dr. George H. Rohrbacher, Stockton specialist in dermatology, who has just been retired from the United States Army due to physical disability, with the rank of lieutenant colonel, will reopen his offices in the Medico-Dental Building about November 15.

Lt. Col. Rohrbacher served in the South Seas two years. He was in charge of the 13th Station Hospital in Townsville, Queensland, Australia. At one time he was in charge of sanitation and medical services in the Darwin area. He entered active service in World War II on March 3, 1941, when the 143d Field Artillery was called to the colors.

Before resuming practice he will attend a medical school in New Orleans for about six weeks to "brush up" in various phases of his profession. Dr. Rohrbacher will be associated with Dr. Eric Rosenberg, who has been in charge of his offices since Dr. Rohrbacher went to war.—Stockton *Record*, September 22.

Banning (Riverside County) Homes Medical Plan Ends

Banning Homes' pre-paid medical plan, sponsored by the California Physicians' Service, was discontinued July 15 for lack of required 90 per cent participation.

The plan attracted about half of Banning Homes' 2000 families. Howard Holtzendorff, Housing Authority executive director, reported.

The Federal Public Housing Authority in San Francisco notified Holtenzendorff that it no longer could continue to subsidize the plan as it has during its year's existence.

Steps are being taken now to staff the Banning Homes' medical center with two doctors who will attend residents on a fee-for-service basis.—San Pedro *Shipyard Worker*, July 13.

Blue Cross Plan Claims Big Gain In Members

Chicago—(AP)—Nearly 15,000,000 persons now are enrolled in the nonprofit Blue Cross plan for paying hospital bills, and more than 1,011,000 are members of the medical service plans coördinated with Blue Cross Hospitalization, Dr. C. Rufus Rorem, director of the American Hospital Association Service Plan Commission, said yesterday.—Sacramento *Union*, July 28.

Chiropractors

Their Annual Convention Selects "Perfect Backs"!

A thousand chiropractors from all parts of the country are gathered here today for the twenty-second annual National Chiropractic convention, it was announced by Dr. Charles H. Wood, convention host.

Three daily sessions will be held at the convention offices, 920 Venice Boulevard, with lectures and demonstrations of new techniques presented by leading members of the profession, Wood said.

Pretty Miss Margaret Marquis, 25, of 730 Maple Street, Burbank, was selected among 20 girls as having the most perfect back at the preconvention dinner-meeting held by the Santa Monica District, California Chiropractic Association, in Santa Monica yesterday. Runners-up were Edna Rivers and Evelyn Most, both of Santa Monica.—Los Angeles *Herald and Express*, August 28.

Depleted Doctors' Ranks May Be Aided by Women

Because of the limited supply of physicians, there soon may be an increase in the number of women medical students.

Reporting also, as another wartime trend, that several states are contemplating the formation of new medical schools "to provide doctors for rural communities," the

Journal declared that such moves will not solve this problem.

"We may expect increases in the enrollment of women in the next entering classes, with the current limitations on the supply of qualified men," is a statement made in a report by the A.M.A. Council on Medical Education and Hospitals.

"However, it is not apparent that there is a large reservoir of qualified women students interested in and prepared to study medicine . . . Should schools determine to admit a considerably large proportion of women in the future, they would probably be unable to do so without accepting students with qualifications inferior to those required in the past from either men or women."

Discussing the lack of physicians in some rural areas, the report said:

"New and more medical schools will not solve the problem of distribution of medical care.

"There is no assurance that more doctors will practice in rural communities if more doctors are produced. The rate of production of doctors and their adequate distribution are independent problems."—Long Beach *Press-Telegram,* August 17.

Keep U. S. Physicians Out of Politics

The recent report of selective service officials that one-third of our population lack physical fitness may be seized upon by proponents of socialized medicine as an argument in favor of the Murray-Wagner-Dingell bill in Congress which calls for compulsory health insurance.

One selective service official declared: "Health is a major manpower problem and it will require the all out effort of everyone to correct this situation and prevent a recurrence."

With this statement we can agree. But it should not be taken to mean that all the people of the nation should be saddled with a heavy tax in order to meet the needs of the ailing one-third. It should be remembered that under the Murray bill social security payroll taxes would jump from the present one percent to six percent for both employers and employees.

In our anxiety to correct a bad situation we are in danger of creating other conditions which, in their way, are equally undesirable. It has been pointed out that socialized medicine would have a demoralizing effect on the medical profession. It would make federal employees out of our physicians.

The United States Public Health service has been given authority to make grants-in-aid or medical research in public or private institutions, increase appropriations to states engaged in general public health work, establish a national tuberculosis program, and foster preventive medicine.

It would seem that such coöperation by the government with both public and private agencies is one of its legitimate functions in carrying out any public health program. It is not compulsory, but it does provide a basis for coördinating the medical facilities of this nation, and making the results of medical education, research and practice available to individuals, doctors, and hospitals in every city and rural community.

If the hand of politics can be kept out of the United States Public Health Service it can be the focal point for encouraging rapid strides in progressive American medicine.

Coördinating public and private health activities for the benefit of all the people is far better than socialized medicine for one-third of all the people financed by the entire group. This, without destroying the initiative of American medicine by creating a national medical monopoly and compulsory medical practices, is the goal that must be kept in sight.

If there is any agency of government that should coöperate with all health agencies it is the United States Public Health Service. Let us hope that it will be its policy and that private medicine may work with it with a feeling of security rather than fear.

George Gordon Byron (1788-1824).—Was it a form of talipes or Little's Disease? Were one or both feet affected? Whatever the true nature of the deformity, it affected the life of the embittered Byron. This remarkable man, to whom walking was a sore task, might have become an illustrious soldier, besides a great poet and rather promiscuous lover, and his noble verses might then have told tales of even greater epic beauty. Byron never permitted anyone, not even his physician in his last illness, to view his deformity.—Warner's *Calendar of Medical History.*

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

California Workmen's Compensation Act as it Affects Physicians and Surgeons

This is the third of a series of articles commencing in the September, 1944, issue of CALIFORNIA AND WESTERN MEDICINE, with reference to the above subject and with particular emphasis being placed upon the fees of physicians and surgeons in industrial accident cases.

After the various proceedings described in Medical Jurisprudence articles of the September and October issues of CALIFORNIA AND WESTERN MEDICINE, on the petition by the California Medical Association for the adoption of a new fee schedule for industrial accident cases, the Industrial Accident Commission, on July 18, 1944, adopted an order providing for a surcharge over the existing fee schedule. The resolution of the Industrial Accident Commission providing for a 15 per cent surcharge reads as follows:

> "Whereas, In recognition of the increased cost involved in the furnishing of medical services under present wartime conditions, an overwhelming majority of the insurance carriers and self-insured employers have voluntarily agreed with the California Industrial Accident Commission to pay a 15 per cent surcharge on all fees covered under the existing California Medical Fee Schedule; therefore be it
>
> "Resolved, That the Industrial Accident Commission does hereby authorize this surcharge, which is to be effective as to all medical and related services rendered under the provisions of the California Workmen's Compensation laws on and after August 1, 1944, same to continue for the duration of the war. 'Duration' is defined as extending until six months after the cessation of all hostilities in which the United States is now engaged; further
>
> "Resolved, The term 'medical and related serivces' shall include x-ray, laboratory and physiotherapeutic services, whether furnished by practicing physicians, laboratories or hospitals; further
>
> "Resolved, Medical charges on cases presently under treatment shall be segregated so that services furnished prior to August 1, 1944, will be charged for on the basis of the then existing medical fee schedule, and the surcharge of 15 per cent shall be applied only to treatments and services on and after that date; further
>
> "Resolved, That the Commission hereby declares its intention to ask the various parties at interest—the medical fraternity, self-insurers, insurance carriers and the appropriate State Departments—to form a study Committee for the purpose of collaborating on a permanent medical fee schedule to become effective after the 'duration'."

The result of this surcharge order is that every physician rendering professional services in industrial injury cases is entitled to receive for his services, a fee not less than the fee prescribed in the old fee schedule, plus 15 per cent.

It has come to the attention of the California Medical Association that some of the insurance companies writing workmen's compensation insurance have asked that physicians rendering services in industrial cases agree to continue under the old fee schedule and to waive the 15 per cent surcharge authorized in the Commission's order above quoted. The allowance of a 15 per cent surcharge is an official act of the Industrial Accident Commission so that the present fee schedule, which sets out minimum fees, is the old schedule plus 15 per cent. Any member of the California Medical Association who agrees with any insurance company to charge less than this approved schedule is, in substance, guilty of fee splitting. In addition, any physician so doing is guilty of violating the agreement between the Association and the Industrial Accident Commission that the Commission's schedule would not be ignored.

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† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

Every physician and surgeon rendering services under the California Workmen's Compensation Act, is entitled to reasonable fees for his services. When the Industrial Accident Commission made this order as its official act, it constituted the commission's decision as to what constitutes reasonable fees and, under the law previously discussed, the commission has the power and authority to determine what is reasonable.

It is the recommendation and advice of the California Medical Association that every physician refuse to make any agreement with an insurance company to charge fees less than those permitted by the Industrial Accident Commission's surcharge order. Every physician has an unqualified right to a fee in the amount set forth in the old fee schedule, plus the 15 per cent surcharge, and there are legal means for enforcing payment of these fees before the Industrial Accident Commission.

In *Independence Indemnity Company v. Commissioner,* 2 Cal. (2d) 397, the State Supreme Court held that the Industrial Accident Commission has jurisdiction to hear a proceeding originally commenced by a physician to recover the reasonable value of his services if the injured employee is made a party to the proceeding. Under *Labor Code Section 4907,* in such a proceeding, the Commission has power to determine what amount constitutes reasonable compensation for the services rendered. In the event that any insurance company or employer refuses to pay a physician the amount of the old fee schedule plus 15 per cent, the physician may file a petition with the Industrial Accident Commission in which he names as defendants the employer, the employer's insurance carrier, and the injured workman to whom he rendered services. The filing of such a petition gives the Commission jurisdiction to determine the controversy over the physician's fee. In exercising this jurisdiction, the Commission may award the physician a fee based upon the old fee schedule plus the 15 per cent surcharge authorized on July 18 of this year.

It is imperative that every member of the California Medical Association comply with the Commission's order and in this article we wish to emphasize, *first,* that no physician need enter into an agreement with an insurance company to accept less than the fee permitted under the surcharge order, and *second,* that every physician has a legal right which he may enforce before the Industrial Accident Commission to collect the full amount of his fee based upon the surcharge order of the Industrial Accident Commission. (For other comment, see CALIFORNIA AND WESTERN MEDICINE, for October, on pages 182 and 215.)

Problems of Medical Legal Testimony in Industrial Injuries

Dr. Rutherford T. Johnstone, specializing in industrial medicine, was the speaker at the meeting in this city of the Casualty Insurance Adjusters Association of Southern California on August 24. He spoke on "The Problems of Medical Legal Testimony."

Dr. Johnstone declared that the approach of a claims man from an insurance company to a victim of an industrial accident, frequently puts the case into a claim when, if properly approached, the victim would not have been given the thought that he should get all he can from the insurance carrier.

He also said that the doctor frequently is to blame for instilling the same idea into the patient's head. He pointed out that when an employee was injured, the physician did not examine the man, but sent him to hospital attendants for treatment. He declared that this failure to examine the man quite frequently brings the case into the classification of a legal medical case.

Dr. Johnstone pointed out that occupational diseases will show greater percentages in the future, and that the average industrial doctor is not interested in occupational medicine. He said the adjuster or claims man should be sure to get accurate information from the doctor.

He said that industrial medicine is not being given its true place in medical schools, and that it should be on a plane with other types of medicine and should be so taught in the medical schools.

The speaker made the statement that if industrial accident cases were presented properly many would be settled with greater equity to all concerned, than is the case now.—San Francisco *Underwriter's Report,* August 31.

Riverside County Denies Death Claim for $50,000

A claim for $50 000 against the County of Riverside, the treasury of Riverside county, each of the five supervisors, Dr. Bessie Martell, medical superintendent at the county hospital, Ellis Browning, resident physician at the county hospital, Howard Hart, resident physician at the Blythe branch of the county hospital and F. V. Rudd, business manager of the county hospital, was presented to and denied by the board of supervisors recently. The claim, charging the wrongful death of John M. Jones, Jr., of Blythe, was filed by Lavenia C. Jones mother of the deceased, who claims that the death of her son was due to negligent and careless and unskilled treatment on the part of the county medical staff members at the Blythe hospital when the boy was operated on June 27 for removal of the appendix.

Doctor Wins Suit Over Autopsy

Martinez, Aug. 25.—A 1937 telephone bill, showing a collect call on October 7, was put into evidence yesterday to win dismissal of Mrs. Emma Adford's $15,000 damage suit against a Walnut Creek physician and a funeral home.

Carl O. Alexander of San Francisco, attorney for Mrs. Adford, asked Superior Judge A. F. Bray to dismiss the suit and discharge a jury which had heard three hours of testimony in the case.

"I am satisfied that the coroner, Dr. Bolender and the funeral home did what they were required to do under the law," he said.

Mrs. Adford had charged that an autopsy performed on the body of her husband, Thomas C. Adford Walnut Creek barber, was without her authorization. The post mortem, performed by Dr. Melvin C. Bolender at the Guy Funeral Home, disclosed that Adford died of a cerebral hemorrhage.

Dr. Abbott, after explaining that "the difference between an autopsy and a post mortem is the same difference between a bucket and a pail," produced his telephone bill for the month in question to show that Deputy Coroner Winton Blackwell had called him and obtained permission to order the autopsy.

Judge Bray commented that the only issue involved in the action was whether the coroner or his deputy had authorized the autopsy.—Oakland *Tribune,* August 25.

Treatment of the pregnant woman with tuberculosis by the most modern methods of combating the disease together with equally modern prenatal care apparently offers her as good a chance for recovery from her tuberculosis as though pregnancy did not exist.—E. S. Mariette, M.D., et al., *Trans. Nat. Tbs. Assn.,* 1941.

LETTERS†

Concerning "Tuberculosis Supplement" of August C. & W. M.:

(COPY)

California Tuberculosis and Health Association
45 Second Street
San Francisco 5, California

Dr. George H. Kress, Editor,
California and Western Medicine,
San Francisco 8, California.

Dear Doctor Kress:

The California Tuberculosis and Health Association is grateful to you and California and Western Medicine for again printing the Tuberculosis Supplement this year. It will be presented at the meeting of our Board of Directors in Los Angeles.

This service of California and Western Medicine is one of the best pieces of professional education in tuberculosis work that is being done in the United States. We are very grateful to you.

Best wishes!

Very truly yours,
(Signed) W. F. Higby, *Executive Secretary.*

Concerning Mandatory Attendance at County Society Meetings:

(COPY)

———— County Medical Society, addressed.

Dear Doctor ————:

We have for attention your letter, regarding the possible amendment of the by-laws of your society to provide a minimum attendance at meetings of the society as a prerequisite to active membership.

If a by-law providing that each member of the society must attend at least three meetings per year or be subject to penalty is duly and regularly adopted by the society, we see no reason why it should not be binding on all members of the society, including those who have been members under the old by-laws.

We have received a similar inquiry from Dr. ————, quoting the proposed by-laws. They are denominated: "Section 5. Termination of Membership," "Section 6. Membership in Good Standing," and also Section 4, Chapter 5 setting forth the duties of the secretary-treasurer in connection with the keeping of attendance records and the consideration of excuses for absences.

A provision for termination of membership and expulsion from the society for failure to attend a minimum number of meetings is probably enforceable, but is, in our opinion, ill advised. In the event of action by the society under these sections against a member of long standing, there might be some merit in a contention that a physician who had been a member of the society for many years past should not be expelled from the society for failure to attend meetings.

We believe that legal difficulties could be avoided and your objective attained by the imposition of some less drastic penalty for failure to attend meetings. For example: you could provide that any member who fails to attend three meetings of the society each year and who does not present satisfactory reasons for his absence to the executive committee shall forfeit any right to hold office in the society; or should, upon action by the executive committee, be subject to double dues. Perhaps some other penalty which would be equally expedient may occur to you.

After you have considered the matter further, if we may be of assistance please let us know.

Very truly yours,
Hartley F. Peart.

Concerning Censorship of "California and Western Medicine":

(COPY)

The Office of Censorship
Chief Postal Censor
Washington 25
September 25, 1944

California and Western Medicine,
California Medical Association,
San Francisco, California.

Gentlemen:

It no longer will be necessary for you to submit advance copy of your publication in any form to the District Postal Censor. From now on just mail your export copies when they are ready to go. Our records provide convincing proof that you fully understand the workings of the Code of Wartime Practices for the American Press and that we can confidently depend on you and your staff to do your own censoring, using the Code as your guide.

Your exported material will, of course, continue to be examined while we are at war, but we have arranged for a speedy handling and there will be little or no delay to your shipments. If what appears to be a Code violation is found in your publication, it will be called to your attention by the Press Division, Office of Censorship. As always, the Press Division, located in the Apex Building here at Washington, will be available day and night for advice and help. The Press Code will be, as in the past, the only criterion for judging whether published information is of value to the enemy.

Your continued coöperation under this Code will be of real service to the war effort, for security is best protected, not by trying to stop information at the border but by preventing it from ever reaching print. Please feel free to take up with either the District Postal Censor or this office any immediate Censorship problems this change may entail.

Sincerely yours,
(Signed) N. V. Carlson,
Colonel, G.S.C.,
Chief Postal Censor.

Concerning U. S. Treasury Department Checks:

California and Western Medicine,
San Francisco, Calif.

Gentlemen:

Because of the increase in the number of checks issued by the Treasury Department, the United States Secret Service continues its campaign against the check forger through its KNOW YOUR ENDORSER program.

It is desired that this program be given as much publicity as possible in an effort to reach all recipients of U. S. Treasury checks and warn them against the theft of their checks, and to warn the merchant against cashing these checks for strangers without proper identification.

Thanking you for your coöperation, I am,

Very truly yours,
William A. Merrill,
Supervising Agent.

U. S. Secret Service,
P. O. Box 3534,
San Francisco 19, Calif.

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† California and Western Medicine does not hold itself responsible for views expressed in articles or letters when signed by the author.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVII, No. 11, November, 1919

EXCERPTS FROM EDITORIAL NOTES

WANTED! An able-bodied kicker, capable of running one perfectly good Medical Society.—It is often asserted by members of the society, especially by the down and out, that they take no interest in the Society because it is run by a clique. This clique is supposed to govern the policies and control the destinies of the organization. It is alleged that this clique excludes them from the privileges and benefits of the Society. . . .

There are men who are prominent in our organization because they are willing workers; because they supply the kinetic energy necessary to its life. These men sacrifice their personal interests, their comforts and their economic welfare in the cause of the many. It is altruism, not selfish interest. They may be wrong at times, they may be headstrong, they may lack vision, but they are willing to serve, where others only stand aside and criticize. They are the clique. They are also your servants. You are the masters. . . .

Los Angeles and San Francisco Physicians Skip This.—The *Journal* will endeavor to serve the interests of the average doctor outside the larger cities by devoting whatever space is necessary to short summarized case reports of usual or unusual cases occurring in the actual practice of any doctor outside the cities of Los Angeles and San Francisco. Send them in. Any case that is of special interest to you. Any case that you would like to have discussed from the standpoint of diagnosis, treatment or in any other way. No bibliography, no "literature," just the concise description of the case. Your name will not be published. Only the case record will appear. With it will be such discussion as any one wishes to offer. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Plaster Methods of Treating Muscle Contractures Following Wounds," by Major George J. McChesney, M.D., San Francisco.—A large percentage of wounds in the late war caused contractures of the muscles and fascial tissues of the upper and lower extremities, restricting motion in the neighboring joints. If we found the joints normal or with only slight adhesions, and the bones sound or with well healed fractures, we still had left a large group of wounds in the treatment of which the following methods, as developed at the Special Military Surgical Hospital at Birmingham, Eng., have given excellent results. . . .

From an Article on "Pathologic Indications for Cholecystectomy," by Andrew Stewart Lobingier, M.D., F.A.C.S., Los Angeles.—A singular divergence of opinion amongst surgeons of large experience continues to appear on the indications for cholecystectomy. If one were to venture to find a reason for this confusion it would probably be seen in a too broad generalization concerning the pathology justifying the removal of the gallbladder. For instance, one authority advises a cholecystectomy in every case of inflammation because the patient makes a more prompt and uncomplicated recovery. . . .

(Continued in Front Advertising Section, on Page 14)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.
Secretary-Treasurer

Board Proceedings

The annual meeting of the Board of Medical Examiners was held in Sacramento, October 16 to 19.

The following officers were elected for the coming year:

Percival Dolman, M.D., San Francisco, President.
Karl C. Gummess, M.D,. Los Angeles, Vice President.
Frederick N. Scatena, M.D., Sacramento, Secretary.

The following actions were taken by the Board:

Harris, Frederic D., M.D. License restored October 16, 1944; five years' probation with the condition that he abide by all laws and report at the spring meeting of the Board at Los Angeles during the term of his probation.

Lashier, Harold, M.D. License restored October 16th, 1944, and placed on five years' probation without narcotic privileges. He is required to report at the October meeting of the Board in Sacramento each year during the period of his probation.

Koerber, Lillie L., M.D. October 17, 1944, license restored on order of the Superior Court.

Lundegaard, Edward M., M.D. On October 18, 1944, placed on probation for one year.

News

"William Edward Grey, 49, of Albany, was acquitted by an all-woman jury late yesterday in Vallejo Police Court of charges of violating the Business and Professions Code by practicing healing without a State medical license. The jury deliberated less than 20 minutes. . . . Climax in the parade of witnesses came when Grey himself took the witness stand yesterday morning. He described in detail his arrest last July by Joseph W. Williams of San Francisco, State medical examiners' special agent. Grey denied that he had acknowledged the title of 'doctor' when Williams appeared July 10, asking 'Is the doctor in?' The agent previously had testified that Grey had replied: 'I am. Won't you be seated'." (Oakland *Tribune*, Sept. 22, 1944, from Vallejo press dispatch same date.)

"Superior Judge Emmet H. Wilson yesterday upheld an order of the Board of Osteopathic Examiners revoking the license of Leslie R. Nunn on charges he aided an unlicensed person in performing a tonsillectomy on two boys who died following the operation. Nunn had asked for a writ of mandate compelling the board to vacate its order revoking his license as a physician and surgeon and charged the board accepted evidence without his knowledge. Nunn and Harry Navarre, a chiropractor, are now in San Quentin serving terms for the deaths of Thomas Richmond, 6, and John W. Childs, 9, who were operated upon by them." (Los Angeles *Examiner*, Sept. 13, 1944.)

"After a State pharmacist testified yesterday that he had found a bottle containing 84 suspicious tablets in the office of Dr. Milton Novotny of 330 W. Ocean Blvd.,

(Continued in Back Advertising Section, on Page 54)

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

WHOLE LEAF
POWDERED LEAF
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For Uniformity of Potency and Safety—

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UNIFORMITY AT SOURCE. Use of a composite lot of digitalis leaves insures more uniform content of active glucosides.

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Are there Vitamins in Beer?

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 20)

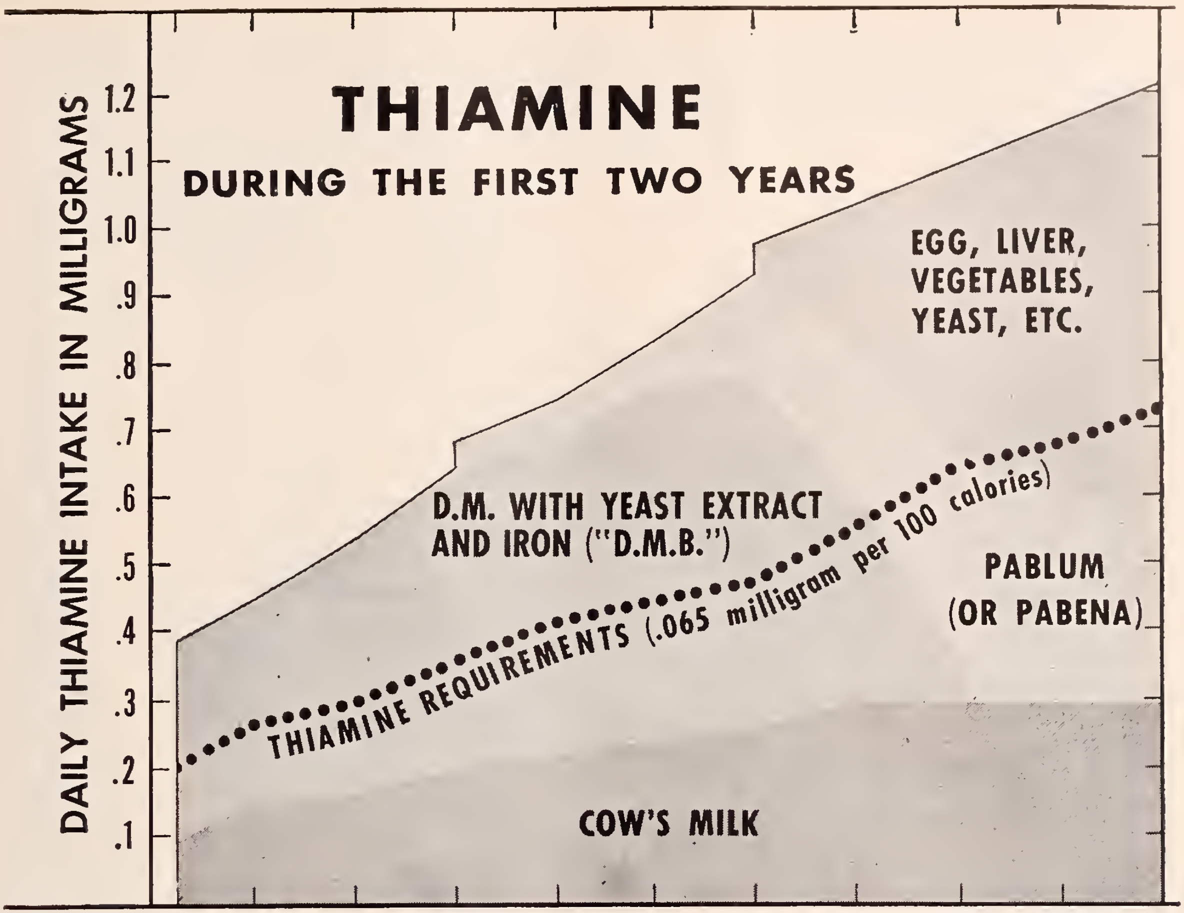
From an Article on "The San Francisco Hospital," by William C. Hassler, Health Officer. Foreword.—While this paper is intended to be descriptive of the magnificent group of buildings now comprising the San Francisco Hospital, it is deemed that a brief history of the old buildings, formerly known as the "City and County Hospital," would properly be in order first.

The Old City and County Hospital.—The original hospital was erected in the year 1872, the contract price being $134,400. Additional ward and operating rooms and a retaining bulkhead were built in 1877, at a cost of $20,000, bringing the initial cost to $154,000. It would be difficult at this time to estimate the amount of money expended for alterations, additions and repairs between 1877 and 1908 (when these buildings were destroyed), but it is fair to assume that it would run into tens of thousands of dollars.

The buildings in question consisted of a group of sixteen structures, located on Potrero Avenue, running from Twenty-second to Twenty-third streets and extending back to San Bruno Avenue, the size of the lot being 866 by 480 feet, or a square city block of dimensions above the average.

For purposes of comparison with the new group a general description of the old hospital would seem proper, the following data culled from an ancient report being quoted: . . .

(Continued on Page 34)



AGE, Mos.	¼	1	2	3	4	5	6	9	12	18	24
WEIGHT, Lbs.	7	9	10	12	14	15	16	19	22	23	25
MILK, Oz.	10	16	18	21	24	26	28	32	32	32	32
"D.M.B.," Oz.	1	1	1¼	1½	1½	1¾	1¾	1	¼	0	0
PABLUM, Oz.	0	0	0	⅛	¼	¼	½	¾	1	1	1

THIAMINE DURING THE FIRST TWO YEARS

Thiamine functions as a component of a cellular respiratory enzyme system, and is necessary for the complete combustion of carbohydrate. Complete thiamine deficiency eventually results in beriberi, which happily is seldom seen in America. However, authorities agree that partial thiamine deficiency in this country is widespread.

In clinical practice, it is desirable to allow a liberal margin of safety over calculated requirements. The chart shows that this safety factor may be assured when the carbohydrate is "D.M.B." and the cereal is either Pablum or Pabena.

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Effective Convenient Economical

THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

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is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

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Fully approved by the American College of Surgeons and the American Medical Association for Resident and Interne Training.

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

Excerpts from Correspondence: Straight from the Shoulder

San Francisco, July 2, 1919.

To the Editor:

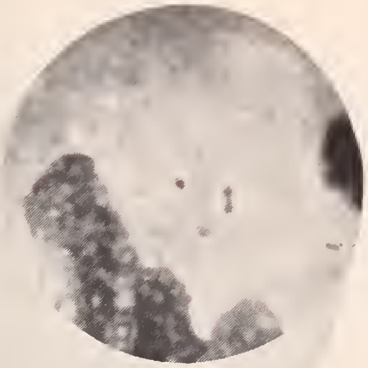
With reference to the communication from the Los Angeles doctor who states that "not one doctor in ten reads the *State Medical Journal*," it would be interesting to know the basis upon which the doctor makes such a statement. The *Journal* belongs to the doctors of the State of California, and, if they do not read it and do not send in communications with reference to its policy, it is the fault of the doctors and not the men who have charge of the *Journal.*

It is generally conceded that the *California State Journal of Medicine* is one of the best of any State society in the United States, and it has stood for higher medical ethics than most any other journal that can be mentioned. If any statement is made in the *Journal* that should be challenged, it is up to the medical profession of the State to send in their objections, and this is what the editor and those who have to do with the policy of the *Journal* are continually striving for—that is, to receive communications so that they may know the desire of the doctors with reference to policy, and things that would be of interest to the profession at large.

It is usually those who do the least that criticize the most, and it might be well to know how much the gentleman who sends in this criticism has done for the advancement of the *Journal.* There is no objection to criticism at any time, provided it is a just criticism, as only in this way can the *Journal* be improved; and if the

(Continued on Page 48)

PNEUMONIA in 1944-1945



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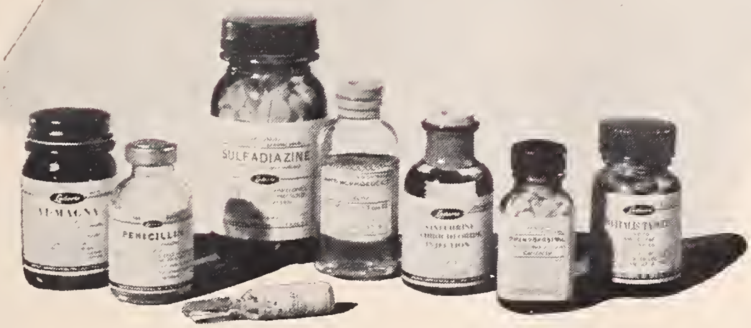

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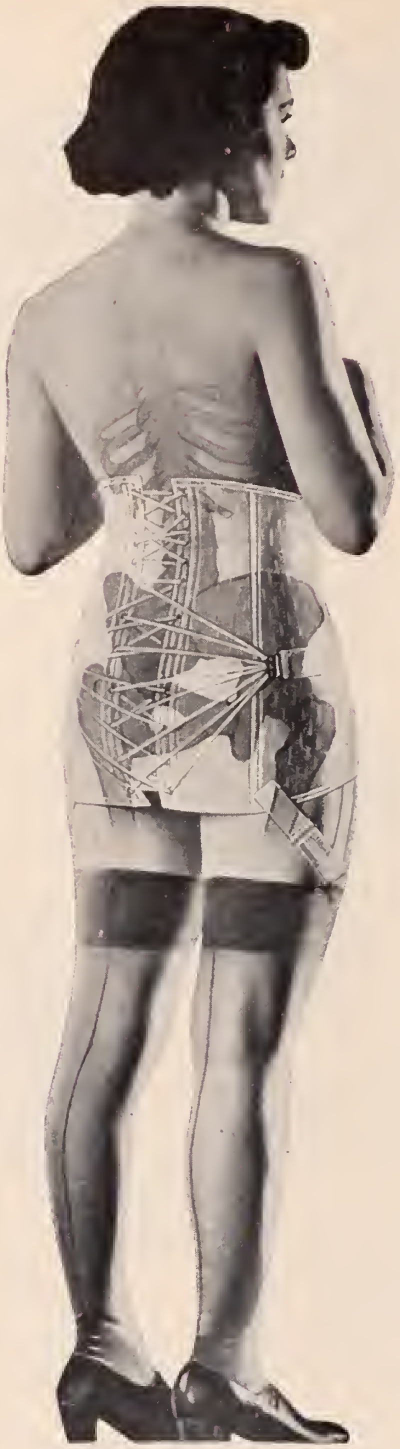

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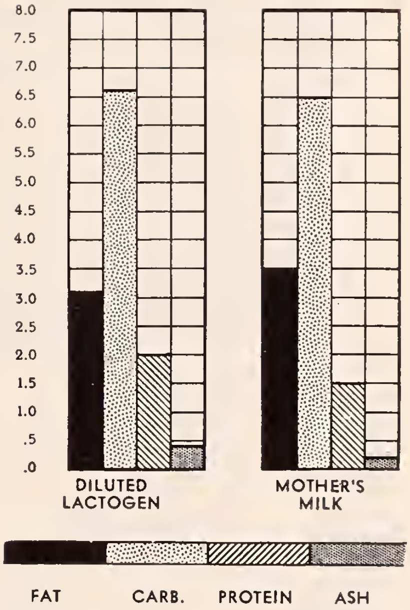
> **John Lovett Morse, A.M., M.D.**
> **Clinical Pediatrics, p. 156**



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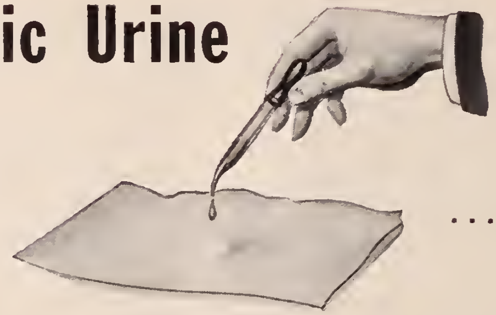

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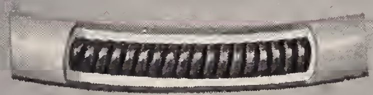
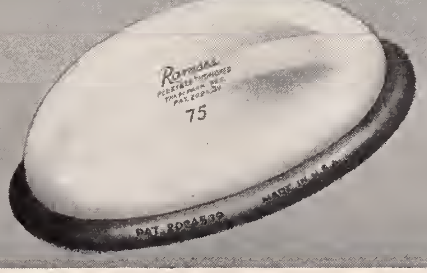
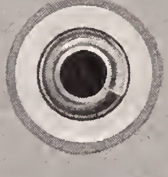


Cut away section of "RAMSES" Diaphragm Rim. Note cushion of rubber tubing which protects against spring pressure; provides smooth unindented area of contact with vaginal walls.





End view of "RAMSES" Diaphragm Rim showing coil spring imbedded in rubber.

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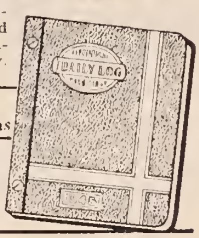

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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

gentleman in question will send in any ideas or suggestions for the improvement of the *Journal*, or anything that will make more people read it, his criticism will be gladly received and followed.

Very truly,

G. G. MOSELEY.

From an Article on "The Use of Homatropin in Refraction," by Percy Sumner, M.D., San Francisco.—A number of years ago, when I was in New York, a paper was read to the Academy of Medicine on the use of homatropin in refraction. As I was at that time a student in the office of the oculist who presented the paper, I was naturally greatly interested in it, as I had had an opportunity of observing some of the conclusions on which the paper was based.

It amazed me to hear, in the discussions that followed, that several men seemed quite opposed to the use of homatropin or any other cycloplegic in refraction, and contended that they got good results by giving the manifest correction, without the use of drops. As I was at

(Continued on Page 54)

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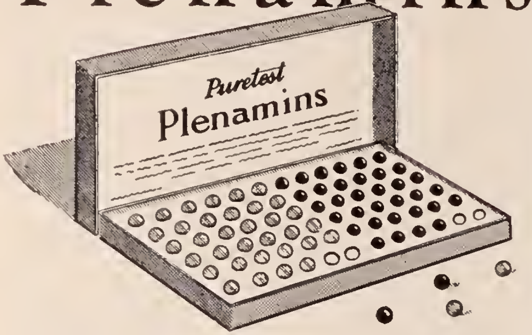

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(Continued from Page 48)

that time fresh from Vienna, where the use of a cyloplegic in refraction was then unknown, and where the results were pronounced very poor by a number of American oculists who had observed and practiced refraction under cycloplegics both in England and America, it was naturally a great surprise to hear any doubt expressed on what I had learned to consider the only way to do a proper refraction. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 276)

and a chemist testified that he had examined some of the tablets and found that they contained morphine, Dr. Novotny was held to answer to the Superior Court on a charge of violating the Health and Safety Code, at the conclusion of a preliminary hearing before Municipal Court Judge Charles D. Wallace. Attorney Russell Pray, representing Dr. Novotny, argued vigorously for a dismissal of the charge and contended that under the law a physician is permitted to keep narcotics in his possession because he is permitted to buy the drugs without a prescription. In denying Pray's motion for a dismissal of the charges, Judge Wallace held that sufficient probable cause had been established to justify a trial in Superior Court. Oct. 9 was the date set for Superior Court arraignment." (Long Beach *Sun,* Sept. 8, 1944.)

"Marking the second time in two years, probation was granted to Dr. William G. Cardew, 77, chiropractor and confessed abortionist, by Superior Judge William F. James yesterday morning. The period of the probation is for five years. . . . Judge James, in addition to making surrender of the license, abandonment of practice, equipment and drugs, conditions of the probation order, also provided that the doctor's premises be open for inspection at all times by county or medical authorities." (San Jose *Mercury Herald,* Sept. 16, 1944.)

"Police Chief George Weight said today Max Otto Garten, 42, Salinas chiropractor, had been arrested on a charge of preforming an illegal operation, and was released on $2000 bail. The complaint was signed by a Salinas woman. Chief Weight said Garten came here two years ago from Los Angeles." (San Jose *Mercury Herald,* Sept. 17, 1944.)

"Elmer Etheridge, 42, who allegedly attempted to play both ends against the middle, is in the county jail on a bribery charge. Etheridge was engaged by the narcotics squad August 10 to make a narcotic 'buy' from Dr. Eugene P. Mathias, 28-year-old osteopathic physician and surgeon, whose offices are at 12232 Venice Blvd., Mar Vista. Etheridge did so, and as a result, Mathias' preliminary hearing was scheduled for Tuesday next. However, Mathias' attorney told police that Etheridge had said he would 'go south' before the hearing if Mathias would fork over $2500 and 100 morphine tablets. Etheridge's bail is set at $10,000." (Los Angeles *Daily News,* August 19, 1944.)

"The Japanese would rather capture American doctors than American generals, because they think a doctor can do more valuable work. This was the declaration here today of Comdr. Glenn G. English, of the U.S.N.R. Medical Corps, as he returned to his Los Angeles home after service that has taken him to Guadalcanal, Tarawa, Saipan and Tinian as a regimental surgeon with the marines . . ." Los Angeles *Herald and Express,* September 6, 1944.)

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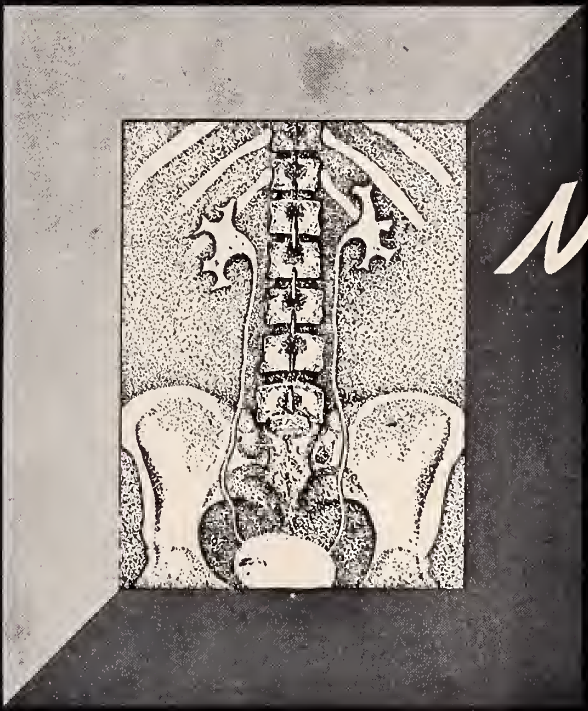

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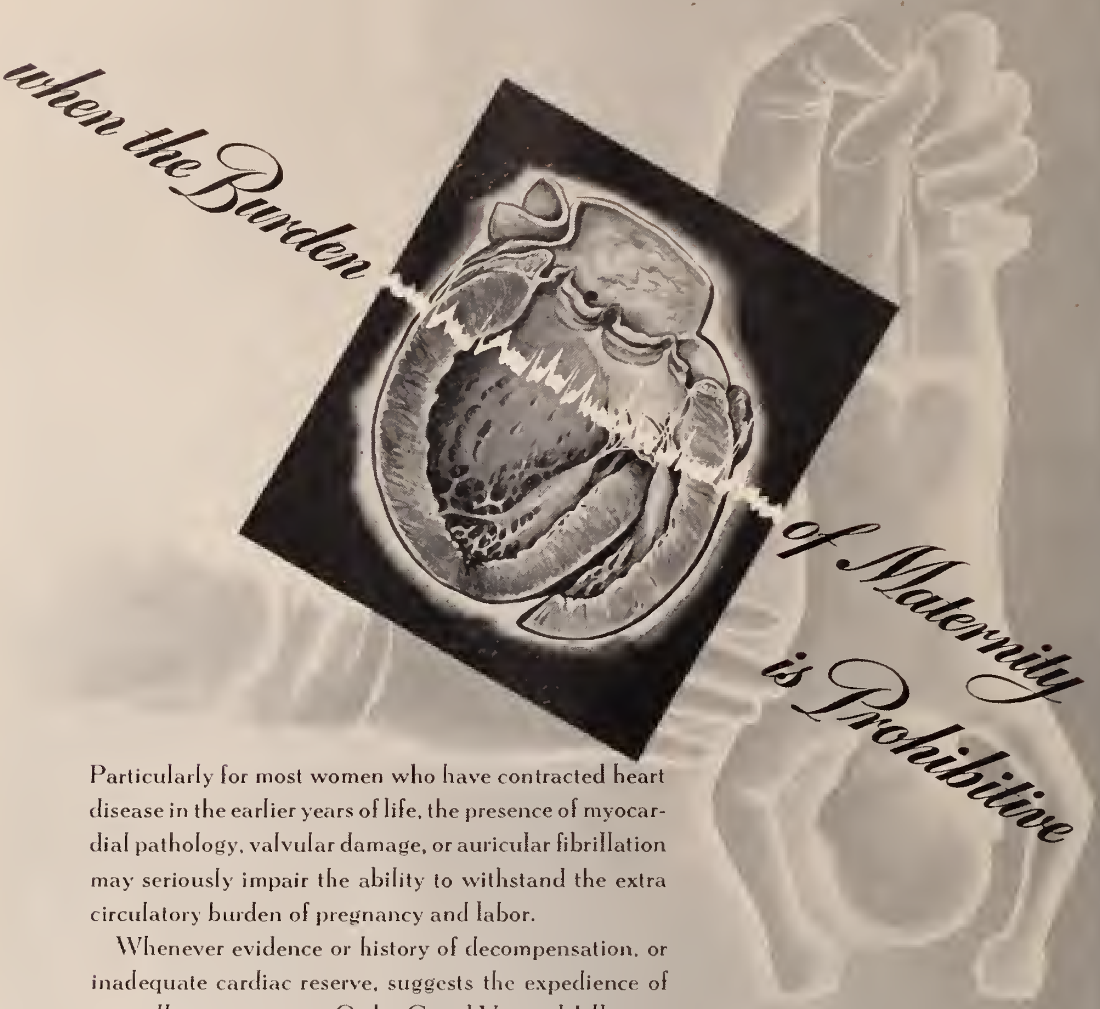

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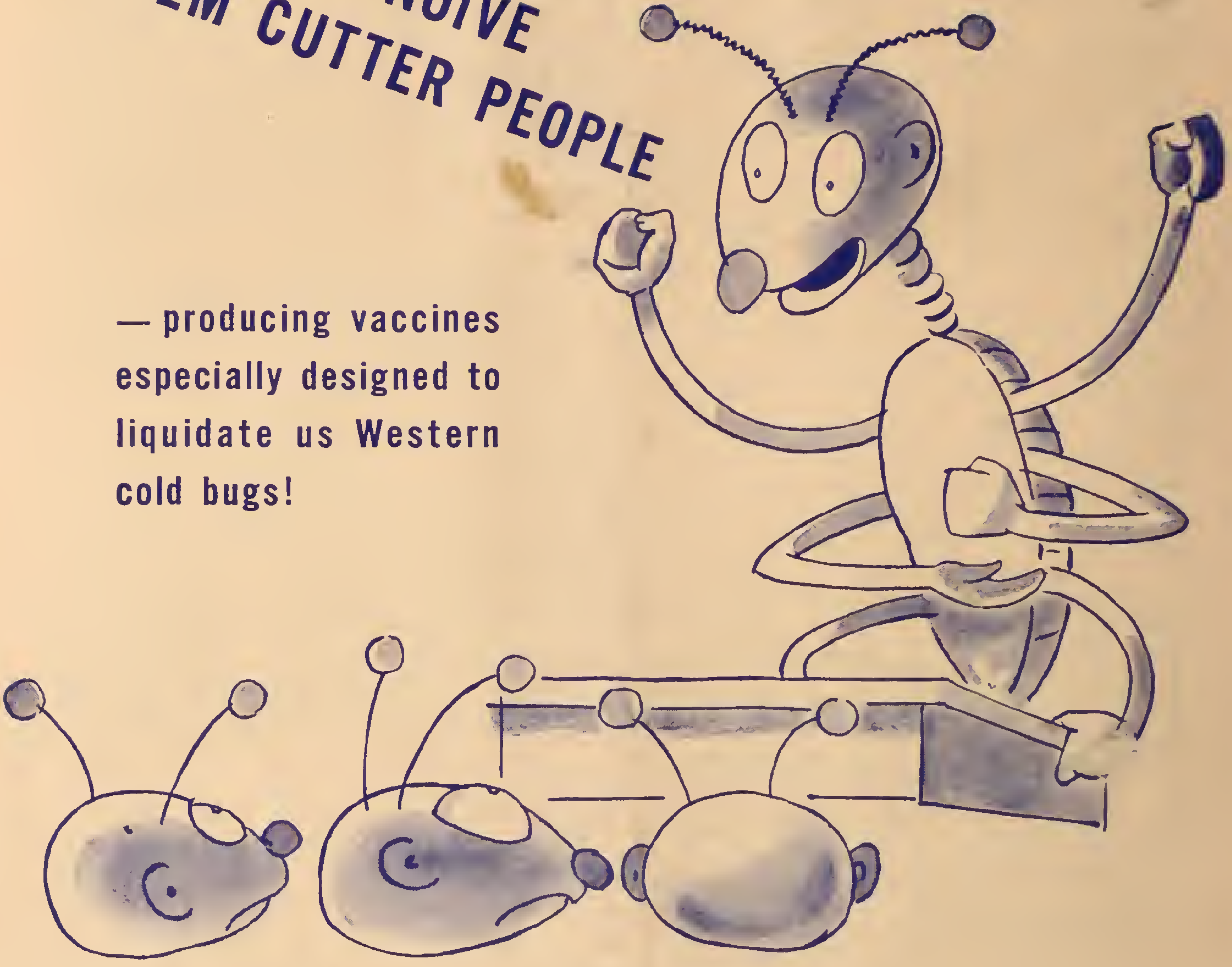

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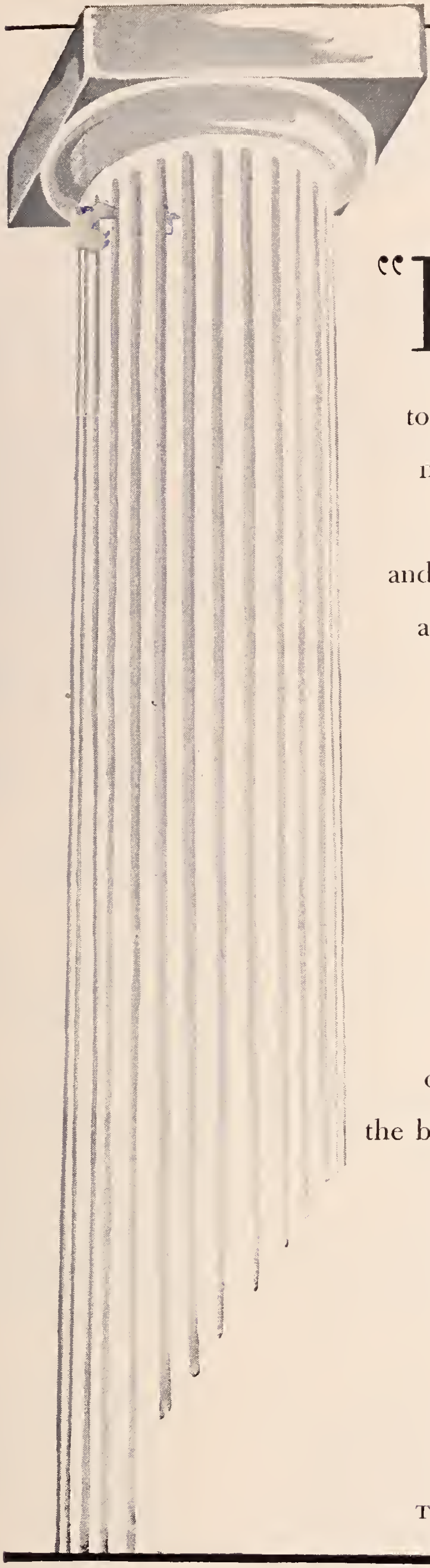

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco 22. Phone MOntrose 3600.

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Women and Men. By Amram Scheinfeld, author of "You and Heredity." Cloth. Price, $3.50. Pp. 453, illustrated. New York: Harcourt, Brace and Company, 1944.

Proteins and Amino Acids. Physiology, Pathology, Therapeutics. Paper. Pp. 189. Yonkers, New York: The Arlington Chemical Company.

An Outline of Tropical Medicine. By Otto Saphir, M.D., Director of the Department of Pathology of the Michael Reese Hospital; Professor of Pathology, University of Illinois College of Medicine. Cloth. Pp. 86. Chicago: The Michael Reese Research Foundation, 1944.

BOOK REVIEWS

Civilization and Disease. By Henry E. Sigerist, M.D., D.Litt., LL.D.; William H. Welch, Professor of the History of Medicine in the Johns Hopkins University. Cloth. Price, $3.75. Pp. 255, illustrated. Ithaca, New York: Cornell University Press, 1943.

A factor whose presence can lose wars, change the personality of entire populations, disturb social life, give rise to new faiths, appreciably affect music, literature, and art cannot but be the vital concern of civilized man. Disease is such a factor. Dr. Henry E. Sigerist has traced its varied and multiple influence upon every aspect of civilization in a book as important as history, as fascinating as legend.

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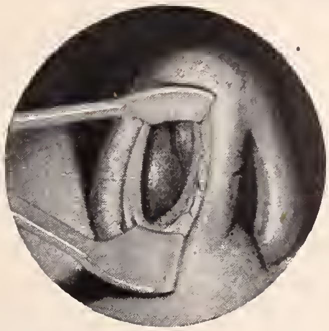
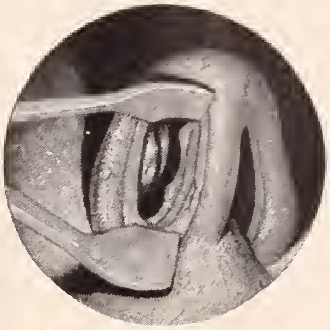


1:52 P. M. Inferior and middle turbinates are highly engorged and in contact with the septum. The airway is completely blocked.



2:01 P. M. Maximum shrinkage has been obtained 9 minutes after two inhalations from Benzedrine Inhaler. The airway is open.

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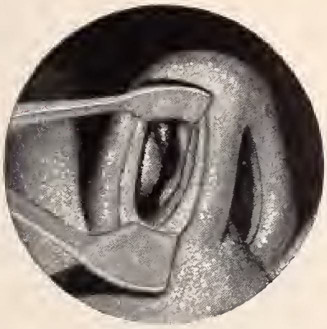
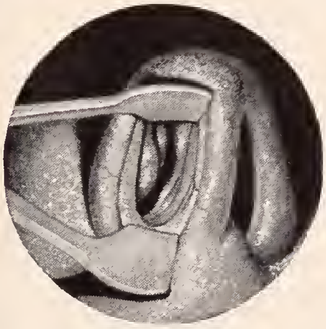


3:15 P. M. Airway is still open. Benzedrine Inhaler produces a shrinkage equal to, or greater than, that of ephedrine.



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Arch. Otolaryng., 39:109-123, 1944.

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(Continued from Page 7)

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Lippincott's Quick Reference Book for Medicine and Surgery. A Clinical, Diagnostic, and Therapeutic Digest of General Medicine, Surgery, and the Specialties, compiled systematically from modern literature. By George E. Rehberger, A.B., M.D. Twelfth edition. Cloth. Price, $15.00. Pp. 1460, illustrated. Philadelphia, London, Montreal: J. B. Lippincott Company, 1944.

This book consists of eleven parts, dealing respectively with (1) General Medicine and Surgery, including Neurology and the Diseases of Infancy and Childhood; (2) Gynecology; (3) Genito-Urinary Diseases; (4) Obstetrics; (5) Skin Diseases; (6) Diseases of the Eye; (7) Diseases of the Ear; (8) Diseases of the Nose; (9) Diseases of the Throat; (10) Orthopedics, including Fractures and Dislocations; and (11) Drugs,—the whole field, indeed, of practical medicine, excepting psychiatry. Each disease or disorder is treated alphabetically.

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(Continued on Page 12)

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 324)

that scurvy is rare in California. This belief is accentuated by the facts that the orange, a well known antiscorbutic, is a common fruit, and that most children of the State eat it frequently. An inquiry into the incidence of the disease shows this idea to be erroneous.

We have been able to collect from three San Francisco hospitals, from the records of a few of our pediatric friends and from our own, a series of thirty-nine cases which have occurred since July, 1917. For the most part, these represent the extreme cases that find their way into the hospitals and into the hands of the children's specialist. . . .

The facts here presented warrant the conclusion that scurvy is not rare amongst children who live in the vicinity of San Francisco. Most of the cases come to the clinics undiagnosed, a state of affairs which suggests that the less evident subacute cases are being overlooked. It is the hope of the writers that this paper may emphasize the need of a close scrutiny of young children in a search for the "fruste" forms of scorbutus. . . .

EXCERPTS FROM CORRESPONDENCE

December, 1919.

To the Editor:

I am a subscriber to your *Journal* since I obtained in Los Angeles license C-F 54 as physician and surgeon, and even before. . . .

Secondly, going as it were from the sublime to the ridiculous, the little stories related by Dr. W. Montgomery in his reminiscence of the Obstetrical Society of

(Continued on Page 14)

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TWENTY-FIVE YEARS AGO

(Continued from Page 12)

San Francisco, might be supplemented by one, a confrere of mine, experienced in his second year of medical practice. He attended a primipara, which made very slow progress; the husband grew uneasy and insisted on a consultation with old Dr. Smith, a quack, who had had many convictions to his record for illegally practicing medicine. The young physician quite reluctantly consented to the consultation. Old Dr. Smith proposed at once quilling. "What do you mean?" said my young confrere. "I will show you," came the answer. Here Dr. Smith filled a goose quill opened at both ends with smoking tobacco, blew it into the nostrils of the woman primipara; the latter was taken with a violent sneezing. At the third sneezing the baby was born, expelled by one extreme contraction of all expulsive muscles.

Sincerely,
(Signed) THEO. J. JACQUEMIN,
506 Clincon Ave.,
West Hoboken, N. J.

EXCERPTS FROM COUNTY SOCIETY PROCEEDINGS: LOS ANGELES COUNTY

The Nurse Anesthetist Condemned.—At the regular meeting of the Los Angeles County Medical Association, October 16, 1919, an instructive and intensely interesting paper was presented by Dr. Walter R. Crane, entitled *"The Lay Anesthetist."*

The paper dealt comprehensively with every phase of the situation involved in the use of "Anesthetic Technicians," laying emphasis on the danger and injustice to

(Continued on Page 20)

The rooster's legs are straight.

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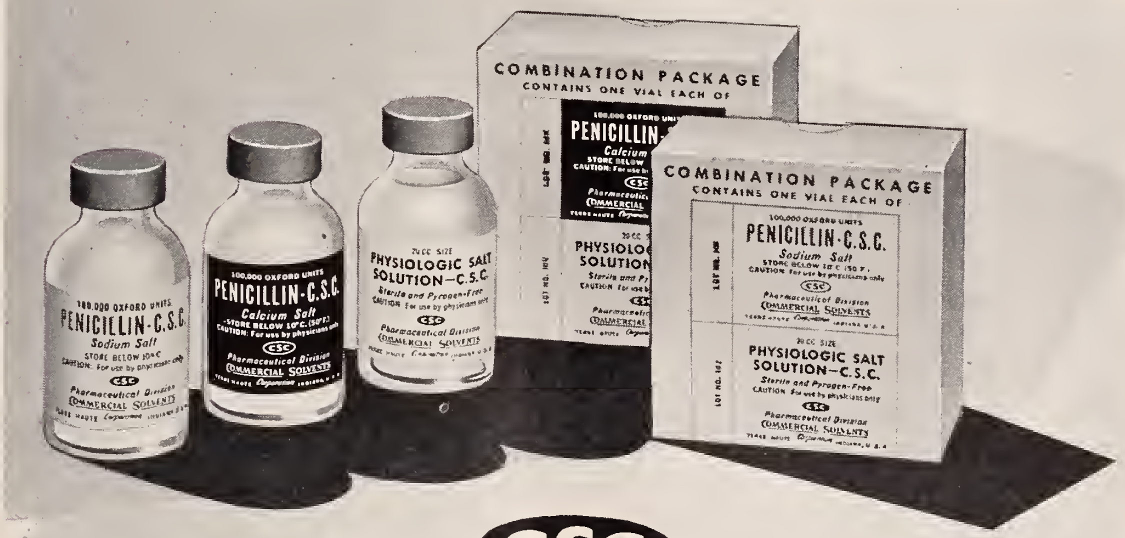
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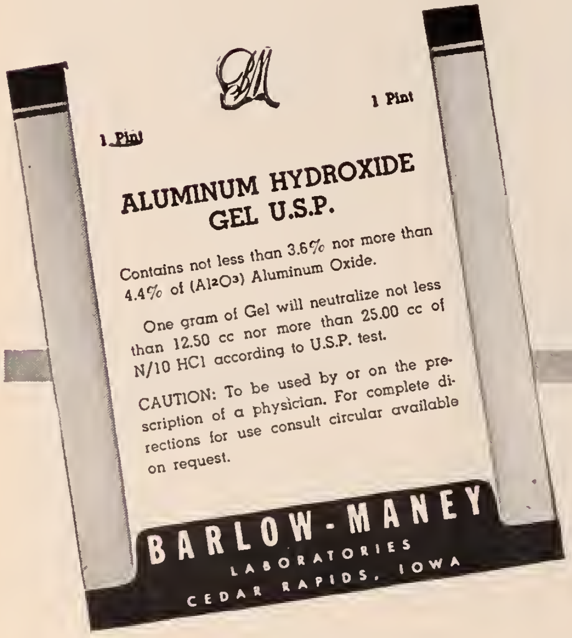

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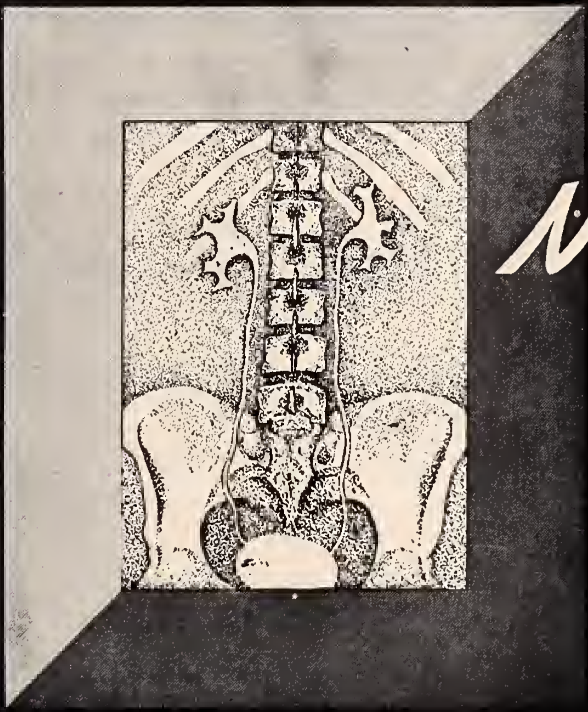

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TWENTY-FIVE YEARS AGO

(Continued from Page 14)

the public, and the growing opposition on the part of ethical members of the profession to the use of the nonmedical, or nurse anesthetist, who, although without basic medical training and with only superficial technical knowledge of etherization, is nevertheless, in reality, intrusted with the patient's life.

He quoted extensively from authorities and observers all over this country and abroad regarding this subject, showing that the consensus of opinion is that lay anesthetists have no place in properly regulated hospitals, or in the private employ of surgeons; that the lives of patients are unduly jeopardized merely for the financial remuneration of the individual or concern employing them.

He cited various authorities in other states than California regarding the legal aspect, and the opinions were to the effect that the surgeon who employs, or the hospital which countenances such practices is liable in case of any accident which may occur either directly or indirectly as a result of anesthesia so administered.

The paper was extensively and favorably discussed by many present and at the close, the following motion was introduced and unanimously adopted by rising vote:

"*Resolved*, That the Los Angeles County Medical Association go on record as in favor of the limitation of the practice of anesthesia to regular licensed physicians and surgeons." . . .

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(Continued in Back Advertising Section, Page 30)

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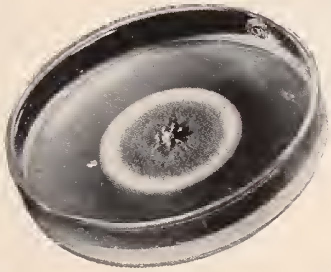

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . GEORGE H. KRESS
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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C.M.A. department, see index below.)
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F. Burton Jones	Vallejo	1947
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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

SEASON'S GREETINGS: TO MEMBERS IN MILITARY SERVICE AND IN CIVILIAN PRACTICE

First, Greetings to members of the California Medical Association who are in military service. To each of you, Season's Greetings from your colleagues who are holding the fort in civilian practice. Those of us who remain at home, wish you who are a part of the Armed Forces to know we are mindful of the sacrifices you have made, and are making, and are proud of your achievements and the splendid manner in which you are exemplifying the ideals of the medical profession, and we pledge you our troth that we shall keep in mind our obligations to safeguard your interests.

In similar spirit, CALIFORNIA AND WESTERN MEDICINE extends to C.M.A. members who are carrying on in the home front, All Good Wishes, and expresses the hope that increased burdens in civil practice will only add to your strength and determination to do all that is humanly possible to permit us to give to all the people of California, the highest quality of medical srevice, in line with the best traditions of the healing guild.

Insofar as the welfare of the medical profession and the public health are concerned, the coming year, and years to follow, will be of vital importance. Let each of us agree to be alert to impending changes, and determined to battle firmly for principles and measures that will not only redound to the best interests of California's citizens, but also make for the maintenance of procedures in medical practice that will permit Doctors of Medicine to carry on their work with greatest good to all.

AMERICAN PUBLIC HEALTH ASSOCIATION: ITS RECENT HASTY ACTION GIVING APPROVAL TO GOVERNMENTAL MEDICINE

How a Minority Group can Commit a National Organization to Policies on Important Issues.—On October 4, in New York, at the annual meeting of the American Public Health Association, its administrative body, the "Governing Council," as represented by 63 out of some 100 eligible members who have power to vote, adopted a resolution by a ballot of 49 in favor of, to 14 against, approving resolutions that are in essence an endorsement of federal legislation that would bring into being compulsory health insurance for the United States.

The story of what took place was well covered in editorial and other comment in the *Journal of the American Medical Association* for October 14th, on pages 434 and 441, and is worthy of perusal by physicians who wish to keep themselves informed concerning current trends that may lead to the establishing of a system of political medicine designed to take the place of scientific medical practice as it has been developed in the United States.

* * *

Reason of Present Comment.—The action taken on behalf of the American Public Health Association receives comment here, not only to call the attention of C.M.A. members thereto, but in order to clear the record of the Director of the California State Board of Public Health, Wilton L. Halverson, M.D., chairman of the American Health Association's Committee on Administrative Practice; who, however, owing to illness, was unable to attend the meeting in New York. The resolution had been referred to Dr. Halverson's committee. Other Californians who were present, and colleagues such as Doctors Haven Emerson of New York, Walter L. Bierring of Iowa and others, were successful in securing postponement of action on the first day of the meeting, by moving to have this agenda item come up for consideration two days later. As a fact, the efforts they made in the meantime, through informal conferences and discussion, failed to prevent the action finally taken; which as stated, resulted in a vote by some 49 Councilor-Fellows in favor of what is practically a political medicine plan, as against some 14 ballots by Councilors who opposed the proposals. Another motion to postpone action and so permit joint consultation with the authorities of the American Medical and American Dental Associations also resulted in failure.

* * *

Significant Complexion of the Governing Council of the American Public Health Association.—The *J.A.M.A.* editorial rightly called attention to the make-up and complexion of the personnel constituting what is known as the "Governing Council of the American Public Health Association." It may be added further, that the membership of the said body is not composed of a majority of physicians. It has been stated to consist, to about 50 per cent, of lay teachers, sociologists and other persons of similar connections; the remaining one-half of the Governing Council consisting of Doctors of Medicine, of whom, perhaps, one-half or more are not physicians in private or general practice, but full time or other public health officials. Consequently, the Governing Council of the American Public Health Association, insofar as a majority of its members is concerned, at the present time may be said to have only limited affiliations with private medical practice, as it is carried on by the great majority of physicians, a group whose members are, certainly, an intimate and important part of the public health background of the United States.

* * *

How Existing System of Medical Practice May be Menaced.—In calling attention to the above, the purpose is to direct the thoughts of practicing physicians to the menace that can arise to existing procedures in medical practice when, in organizations of national scope possessing great publicity potentialities (the American Public Health Association is one of such), the determination of the policies of such organizations, through infiltration or other tactics, is taken from practicing physicians; thus to become the medium through which lay enthusiasts, theorists and similar groups or individuals may carry on to better advantage an educational propaganda in the promotion of objectives to which they are mutually devoted.

* * *

Physicians, Because of Their Indifference, Must Blame Themselves for Some of the Sad Results.—If the action recently taken by the American Public Health Association is examined and clearly thought through, practicing physicians must acknowledge that they themselves need bear a considerable part of the blame for some of the situations that have come into existence.

Years ago should have been visualized, the desirability and need of bringing into close or closer relationship with organized and scientific medicine, those colleagues who were embarking on part or full time careers in public health. This could have been done through establishing of public health sections in our national and state medical associations. Instead, these public health colleagues were looked upon somewhat askance, as if they were not an integral and very intimate part of the medical profession. So that, having no other place of affiliation, they joined other professional groups, or established independent societies. This too, in spite of the fact that public health practice is not only a medical specialty in itself, but is an expression of medical practice that probably possesses greater public relation possibilities than any other specialty group in medicine or surgery.

Such conduct by the medical profession was in great error. One of the ill effects can be noted in the recent action taken by the American Public Health Association.

* * *

C.M.A. Recently Authorized a Section on Public Health.—California, at this year's annual session, took steps to rectify this mistake in procedure. At the recent May meeting in Los Angeles, the newly created Public Health Section of the C.M.A. not only got off to a good start, but on short notice had one of the best programs and largest attendance records of any of the Scientific Sections. Heretofore, in California, the public health officers who have affiliated themselves in the new Section had been obliged to hold their meetings as one of the groups of public officials in the "League of California Cities," or through sessions of lesser attendance, as expressed in the Northern and Southern California Health Officer Associations.

* * *

Actions of the American Public Health Association May Result in Good.—If the recent action taken by the Governing Council of the American Public Health Association will bring home, to the national and constituent state medical associations a realization of the implications involved, when an organization representing a vitally important group of physicians in public health practice is permitted to be infiltrated and practically controlled by outside lay groups, the bitter understanding of what took place may lead to better orientation of the principles and issues at stake, and thus make for decisions to bring such set-ups and proceedings to an end. In other words, the medical profession must move in, and again take possession of its own. If not, then Doctors of Medicine will have only themselves to blame, and must be reconciled to accept the consequences of their own ineptness and inaction.

EDWARD M. PALLETTE

End of a Notable Career.—In the southern section of California, over a long period of years, few members of the profession have exercised greater influence than the late Doctor Edward M. Pallette, whose death occurred in Chicago, on November 16th. An obituary appears in the current issue of California and Western Medicine, on page 317.

Doctor Pallette, an ex-president of the Los Angeles County and California Medical Associations had gone to Chicago to attend a meeting of the Trustees of the American Medical Association to which body he was elected in 1942. He attended meetings of the Trustees on Wednesday, November 15th, but during the night, presumably suffering distress, he had arisen to sit and read, and in the chair in his room at the Palmer House, he was found dead, on the morning of Thursday, November 16th.

Of Doctor Pallette it may be said that in the many professional and civic positions he held, and in his work as physician and surgeon, he always gave of himself in generous, conscientious and efficient service.

Since the beginning of World War II, it was his responsibility to act as the chairman of Procurement and Assignment Service for the southern section of California. In the absence of his son, Lt. Col. Edward C. Pallette (M.C.), Army Air Corps (who had been his office associate), he was at the same time carrying on a large medical practice. The arduous work required in the Procurement and Assignment Service was an additional, and responsible load which, however, in spite of its heavy demands on his strength and health, he willingly accepted as a duty to our Country. His passing takes from the ranks of the medical profession a colleague whose wise counsels will be sorely missed.

C.P.S.: ON PROCEDURES REGARDING CHANGES

California Physicians' Service Now in Its Sixth Year of Service.—California Physicians' Service, the statewide medical service plan inaugurated by and an integral part of the California Medical Association, from the time of its organization some six years ago, has been given a considerable amount of space in California and Western Medicine. As one of C.M.A.'s major activities, an effort has been made in the Official Journal to keep members of the California Medical Association fully acquainted through minutes of the House of Delegates and Council, and through progress and other reports, with the organization and other developments of California Physicians' Service.

* * *

C.M.A. House of Delegates as Administrative Members of C.P.S.—Certainly, when at the annual session held in May of the present year, the House of Delegates recessed, then to be called to order, not as the House of Delegates but as Administrative Members of California Physicians' Service, to hear reports, discussions, and elect trustees of C.P.S., it once again, became plainly evident, that California Medical Association was determined to accept full responsibility for California Physicians' Service, be that for better or for worse. In making the important change in administrative procedure, it was hoped the component county medical societies would appreciate their more direct responsibilities to C.P.S., and their right and obligation to instruct their delegates to express at meetings of the House of Delegates and through communications to the Council, their respective reactions and wishes concerning C.P.S. policies and procedures.

* * *

Basic Changes in Procedure Need Study and Must be Legally Sound.—As has been repeatedly stated in California and Western Medicine, California Physicians' Service was obliged to find its paths of procedure through the hard way,—by trial and error,—since there were no actuarial backgrounds for a service organization of such statewide scope. Officers of California Physicians' Service and members of California Medical Association alike agree that errors have been made. On the other hand, it should be remembered efforts have been constantly exerted to correct mistakes, and as promptly as possible.

A corporation, however,—and C.P.S. is a nonprofit corporation—must act in harmony with the corporate laws of the State and the enabling legislation that applies to a nonprofit medical service corporation. Changes in basic policies and procedures cannot be made over-night nor with undue haste. Since California Medical Association holds an annual meeting, with members of its

House of Delegates acting each year as Administrative Members, it was hoped it would be possible at such sessions to submit for full consideration and action and in regular order, resolutions on proposed changes in organization.

* * *

Letter of Alameda Members and Reply Should be Read by all C.M.A. Members.—In this issue of California and Western Medicine appears a letter submitted by 21 members of the Alameda County Medical Association, they having made request for its publication in the Official Journal. The letter appears on page 302.

In connection therewith also appears the reply of the C.M.A. Executive Committee. The C.M.A. Committee expresses the hope that members of the California Medical Association will take the time to read the communications. They are important. Through perusal and thoughtful consideration by members of the component county societies, clearer understanding of the issues involved in proposed changes will be secured, and the best interests of all concerned will be better conserved.

EDITORIAL COMMENT†

PARADOXICAL RESISTANCE TO TUBERCULOSIS

In the course of a 10 year study of hereditary resistance to tuberculosis Lurie[1] of the Henry Phipps Institute, University of Pennsylvania, noted a marked discrepancy between the rapidity with which certain inbred rabbits acquired airborne tuberculosis and the severity and duration of the resulting disease.

Three rabbit families were tested. One family had a high hereditary resistance and two families a low resistance to injected tubercle bacilli. Injected intracutaneously with 0.2 mg. of highly virulent bovine bacilli, members of the first family survived for an average period of 539 days. The same dose killed members of two susceptible families in an average of from 121 to 141 days. In the resistant family the injection produced a slowly progressive tuberculosis with a tendency to localization, while in the two susceptible families the disease was always of a fulminating rapidly disseminating type.

Animals of all three families were subjected to parallel exposure to airborne tuberculosis, the source of the contagion being a neighboring group of rabbits inoculated intravenously with highly virulent bovine type tubercle bacilli. These rabbits were constantly shedding tubercle bacilli in their urine. Every 2 to 4 weeks the exposed rabbits were tested for acquired skin sensitivity, the onset of airborne tuberculosis being dated from the time the tuberculin reaction became definitely positive.

In a typical experiment all but one of the 8 resistant strain rabbits acquired tuberculin sensitivity in from 0.9 to 3.6 months, an average preallergic period of 2 months. In the two susceptible rabbit strains the pre-allergic period was over twice as long, averaging 4.7 months. Thus the susceptible rabbits were more resistant to airborne tuberculosis than the resistant controls. However, the severity of the resulting disease showed a different picture. The duration of the ensuing fatal tuberculosis ranged from 4.1 to 10.4 months (average 6.4 months) in the resistant family, as contrasted with an average duration of but 3.5 months in the two susceptible families.

From numerous data of this type Lurie concludes that rabbits of high hereditary resistance to injected tubercle bacilli have less efficient portal defenses to airborne tuberbulosis than more susceptible controls, while their internal tissue defenses are more efficient. There is thus a seeming paradox in hereditary resistance to tuberculosis, portal and internal defenses varying inversely with each other. This is a belated confirmation of an early epidemiologic theory, which assumed that there is no necessary parallelism between "Anfälligkeit" or disposition to an attack by a noxious agent, and "Hinfälligkeit" or tendency to succumb to the resulting morbid process. No adequate theory to account for this lack of parallelism has thus far been suggested.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

REFERENCES

1. Lurie, Max B.: J. Exp. Med., 79:573 (June), 1944.

California Medical Association

Important Notice

Attention:

Component County Medical Societies;
Members of House of Delegates;
Members of California Medical Association.

Subject: Special Session of C.M.A. House of Delegates

To be held:

Dates: January 4, 5 and 6, 1945 (Thursday, Friday, Saturday).

Place: Elks Temple, Los Angeles.

Purpose: Consideration of Medical Care Plans in "Official Call."

For other information, see insert page, opposite first Original Articles page (p. 281).

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Important Notice

Members of the California Medical Association, Addressed.

The next California Legislature will convene in Sacramento on Monday, January 8, 1944.

Legislation dealing with present and future medical practice will be submitted.

The constituted authorities of the California Medical Association (your Council and Executive Committee) need your advices.

See over, for the Official Call of a Special Session of the House of Delegates of the California Medical Association, to be held in Los Angeles January 4, 5, and 6, 1945.

Feel free to communicate your opinions to your County Society Officers, your Delegates and your C.M.A. District Councilors.

See over, and read the Purposes of the Official Call, concerning business to be considered.

(OVER)

CALIFORNIA MEDICAL ASSOCIATION

IMPORTANT NOTICE

ATTENTION:

Component County Medical Societies;
Members of House of Delegates;
Members of California Medical Association.

SUBJECT: SPECIAL SESSION OF C.M.A. HOUSE OF DELEGATES

To be held:

Dates: **January 4, 5, and 6, 1945 (Thursday, Friday, Saturday).**

Place: **Los Angeles**

Purpose: **Consideration of Medical Care Plans in Official Call, as noted below.**

CALL FOR SPECIAL SESSION

House of Delegates of the California Medical Association

Notice of Special Meeting

To the Members of the House of Delegates
of the California Medical Association:

The Council of the California Medical Association at a special meeting thereof, duly held on Wednesday, the thirteenth day of December, 1944, at San Francisco, California, by the affirmative vote of all members present, as confirmed by official mail vote, constituting more than two-thirds of all of the members of the Council, adopted the following resolution calling a special meeting of the House of Delegates:

Resolved, That a special meeting and session of the House of Delegates of this Association, California Medical Association, is hereby called to be held at the Elks Temple, at 607 South Park View (corner West 6th Street and Park View, in the City of Los Angeles, State of California, on the fourth, fifth and sixth days of January, 1945, (Thursday, Friday, Saturday), at the hour of 11 o'clock a.m. for the purpose of:

(a) Considering and acting upon legislative proposals relating to state medicine likely to be introduced by certain groups in the coming session of the California Legislature; and

(b) Formulating and acting upon one or more statewide health service legislative proposals satisfactory to a majority of the membership of the C.M.A. House of Delegates; and

(c) Considering and determining the general policies of the California Medical Association at the forthcoming session of the Legislature with reference to legislation or public policy affecting or concerning medical practice in all its phases, payment for the cost of medical care, and all related matters.

Further Resolved, That George H. Kress, the Secretary of this Association, be and he is hereby directed to prepare a written notice setting forth the time and place of meeting and the purposes and objects thereof and transmit the same, signed by him and attested by the President, the Chairman of the Council, and the Speaker of the House of Delegates in the manner and within the time required by the Constitution of the Association.

* * *

SECRETARY'S NOTICE.—Pursuant to said resolution of the Council, you and each of you will hereby please take notice that a special meeting of the House of Delegates of the California Medical Association will be held at the Elks Temple, at 607 South Park View (Corner West 6th Street and Park View), in the City of Los Angeles, State of California, on the fourth, fifth, and sixth days of January, 1945, (Thursday, Friday, Saturday), at the hour of 11 o'clock a.m. of said days, and that the objects and purposes of said special meeting are those objects and purposes set forth in the resolution of the Council, above quoted.

The delegates and alternates who shall be eligible to be seated in the House at said special session shall be those delegates and alternates who were eligible to serve on the seventh day of May, 1944. (At the California Medical Association annual session at Los Angeles.)

(Signed) GEORGE H. KRESS,
Secretary of the California Medical Association.

Attest to Official Call:

LOWELL S. GOIN,
President of the California Medical Association.

E. VINCENT ASKEY,
Speaker of the House of Delegates of the California Medical Association.

PHILIP K. GILMAN,
Chairman of the Council of the California Medical Association.

San Francisco, December 13, 1944.

(OVER)

ORIGINAL ARTICLES

Scientific and General

CIVILIAN WARTIME PROBLEMS IN NUTRITION, FROM THE STANDPOINT OF THE PHYSICIAN*

A SYMPOSIUM†

Lt. Comdr. Dwight L. Wilbur, MC-V(S)-U.S.N.R.
San Francisco

Introduction.—Doctors have not paid much attention to nutrition. In recent years the discovery of vitamins and, subsequently, the mass production of them, have forced upon physicians an awareness of this neglected field of medicine. Doctors usually have had less interest in health than in disease, because the "normal" is usually less stimulating than the "abnormal." In fact, nutritional-deficiency diseases have provoked greater interest among physicians than has any phase of normal nutrition.

If the medical profession is to continue to maintain its high place of leadership in society it must accept full responsibility for guiding society in the firm path of health rather than in keeping it out of the slough of disease. *Good nutrition* and *good health* are inseparable. A successful doctor should be an expert in both of them.

There is much more to the problem of optimal nutrition for all people than simple application of the principles of scientific nutrition. Problems of an agricultural and economic nature, to say nothing of that of food habits, are equally important with nutrition in attainment of "buoyant health" for everyone. Consequently, the physician must associate himself with all sorts of experts to meet satisfactorily the challenge of the great world problem of Food in either war or peace. Proof of the importance of this problem is well illustrated by the fact that the *first* United Nations Conference, with over forty nations represented, met in 1943 to discuss Food.

In an effort to bring a few of the more practical phases of this broad problem to the attention of physicians this symposium has been prepared. In it are represented a background of the importance of Food in wartime, and discussions of certain national and local problems in nutrition, of a normal diet, and of how to attain an adequate diet with rationing of food. From the clinical standpoint, physicians will be interested in discussions of the relations of vitamins to health and disease, of the great need for, and contribution of school lunches to health, and a listing of some of the useful and practical source-material in food and nutrition.

If the symposium is helpful in the solution or other problems, or if it stimulates interest in nutrition, the essayists will have been well repaid for their efforts.

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† *Explanatory Note.* Concerning Four Symposia to appear in issues of October, November, December and January.

In every war there is a tendency to neglect the health, the safety, and the nutrition of those who are behind the lines. Famine and pestilence are facts of war and can be crucial factors in victory or defeat. Our present war is so large and is lasting so long that we will need to be especially alert well beyond the cessation of hostilities.

With the desire to promote optimal health in our civilian population four symposia have been compiled. These have been gathered as follows: (1) Symposium on Disaster Relief, by Henry Gibbons, III of San Francisco, appeared in October issue; (2) Symposium on Communicable Diseases, by Edward B. Shaw of San Francisco, appeared in November number; (3) Symposium on Nutritional Problems, by Dwight L. Wilbur, of San Francisco appears in current issue; (4) Symposium on Industrial Medicine, by Rutherford T. Johnstone, of Los Angeles, will appear in January issue.

* Foreword to a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

THE IMPORTANCE OF FOOD IN WARTIME*

A. J. Carlson
University of Chicago
Chicago, Illinois

THE old saying, that the "Army travels on its stomach," applies with equal force to the civilian population in wartime. For, in modern war, the home front is as important as the battle front. The whole nation fights. Nearly every adult man and woman carries heavier burdens for longer hours at greater speed and this is a tax on body reserves, and calls for more calories and "building stones." But the irony of fate decrees,—perhaps as a reminder (to those who think) of the folly and waste of war,—that this increased need for more and better foods almost always parallels decreased food production, increased food destruction, and increased food waste by spoilage, so that all-out wars, global wars, invariably bring on malnutrition of varying kinds and degrees.

The drafting of ten million men into our Armed Forces, and the parallel increased needs of man power in the war industries interferes with food production on our farms, despite all care to the contrary. Some foods for our overseas forces have been sunk in transit, lost through enemy action on land, and spoiled in too long storage or by hot and humid climates. In countries where the actual battle fronts are located, there are more direct and extensive disruption of food production on the farms, and more direct destruction of food at hand. In addition, under conditions of modern naval warfare, excess foods produced in countries not at war (for example, Argentina) cannot be readily shipped to countries which have food shortage. In brief: war, calling for more than the peacetime calories for perhaps 75 per cent of the adult male population, creates at the same time conditions leading to decreased food production, increased food destruction, and increased food waste. Hence, food has become a mighty war weapon, food may well be the primary factor in victory as well as in defeat.

SOME RESULTS OF FOOD SHORTAGE

When food shortage or food scarcity actually hits a population, all people are not equally affected by this calamity, despite every effort toward rationing and relatively equitable distribution of the foods available. This certainly was the experience in Europe in World War I. The actual food producers, the farmers, will usually be the best fed. There is apparently no way in keeping account of, or securing the various foods on the farms produced in excess of the ration allowed for the farm families. If it comes to a pinch in our own country in the present war, I feel sure our experience will be the same. When foods are actually off the farm—

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Department of Physiology of the University of Chicago.

in transit, in storage, or on sale in the cities—control and equitable rationing can be made more effective and just. But here comes the problem of "Black Markets," which spring up under these conditions in every land, created by those who have little conscience, but plenty of cash, to bribe farmers or middle men in the food industries with prices way above the official ceilings. Hence, the people in the cities with sufficient cash may secure foods in quality and quantity as abundant or more abundant than that of the people on the farm. The people hardest hit by food scarcity in war are obviously the people in the cities, in industries and professions who have not the cash to compete for food in the black markets. That means particularly, the large group of people in the lower income groups. Even without serious food scarcity and the mere beginnings of black markets, as is the case in our country today (because of the rise in food prices, particularly of the better or more preferable foods), the large group of our fellow-citizens who do not share in our wartime pseudo-prosperity, that is, the wartime increase in wages, salaries, and profits will suffer the most. These people find it difficult to secure adequate foods on their relatively decreased income, even though foods are available did they have the price and ration points to buy it in adequate quantities. Relative poverty is a factor that may increase wartime malnutrition, because of high and continually increasing costs of food, even if we should be able to produce and distribute foods as adequately as we have succeeded in doing to date.

In our own country and in Europe, the foods of highest nutritional value to man, such as milk, eggs, meat, fish, and poultry are usually also the most expensive. It was true in Europe in World War I, and has already been indicated in our own country in this war, these highly desirable, highly nutritious but expensive foods being the first rationed, the first to enter black markets, and generally the first to decrease in amounts available so as to upset the average usual dietary of the people in times of peace. As regards our own country in this war, the present scarcity of butter and meat is probably not so much due to scarcity of animal feeds and shortage of man power on the farm as to difficulties with distribution and the increased drain of these foods to our overseas forces and to lend-lease. But it is clear that direct destruction of food and disturbance of normal agricultural processes may reach a point where cattle, hogs, sheep, and chickens compete with man for grain and legumes as food. When that point is reached, it is obvious that cattle, hogs, sheep, and chickens must be sacrificed and all available grain used directly as food for man, since, when grains are fed to domestic animals used for meat, milk, or egg production, we get back in the form of animal food products, on the whole, less than 20 per cent of the food value in the grain so used. Under such conditions, milk, eggs, butter, and meat will practically disappear from the dietary, and man will have to fall back on grain, potatoes, legumes, fruits, and vegetables. I am reliably informed that in Norway 50 per cent of the cattle and 80 per cent of the poultry have been consumed as food in order to render more grain available for human consumption. Our own millions of pet dogs and pet cats compete with man for the superior foods of meats and milk. These dogs and cats are essential neither for victory nor for National existence, especially when men, women, and little children are starving to death in other lands. The American housewife and the American palate will have considerable difficulty, on the whole, to adjust to a dietary nearly or totally devoid of milk, milk products, and meats, even though it is well established that, providing a sufficient variety and quantity of grains, legumes, fruits, and vegetables are consumed by man, these are quite able to sustain growth in the young, and health and vigor in the adult human being.

CONFERENCE ON NUTRITION FOR NATIONAL DEFENSE

We were necessarily perturbed two years ago when, at the Conference on Nutrition for National Defense in Washington, D. C., men in responsible positions of our Federal Government announced that one-third of the American people suffered from malnutrition, and only about 23 per cent of our people could be said to enjoy a good diet, that is, a diet capable of maintaining good health. If this was the condition of diet and health in our country in times of peace and abundance of foods, what must it be under conditions of war when food scarcity of various kinds are almost sure to develop, particularly for lower-income groups in our population.[1] It should be pointed out, and it is a great comfort to know, that the medical examination of our draftees in this war did not indicate such a tragic state of diet and health in our nation. In fact, our draftees in this war are a little taller than the American draftees in World War I, and both of these are taller than the soldiers in our Civil War. The draftees in this war are not only taller, but they are heavier than the draftees 25 years ago. This could not have been the case were malnutrition as extensive in our country as was announced two years ago at the Washington conference, for chronic malnutrition impairs growth and produces underweight instead of overweight.

FAULTY FOOD PRACTICES

Nevertheless, our nation must take stock of our faulty food habits and our faulty food practices for the needs of today and tomorrow, in the case of a prolonged conflict, and for the certain needs of health rehabilitation in many parts of the world when firing ceases. Among our outstandingly faulty food practices is *food waste* in the kitchen and at the table. This is particularly true of food fats. We have developed the agricultural ideal that the fattest hog and the fattest steer is the prize hog and the prize steer. But in the case of the fat steer, most of that fat is wasted, at least as regards human food. Hog fat is used more economically, at least in part, as lard. But it is not only food fats in which we Americans have been wasteful. We do not consider it good form to clean our dinner plates before they are put into the dishpan. Our children are allowed to be wasteful with food, and they usually carry that habit as grown-ups. I have been around in many countries, and while it is true that food waste occurs among people in the upper income brackets in every nation, I know of no other country where the population as a whole has been as wasteful with food as in our own beloved U.S.A. This is *economic* waste, but when men, women, and little children in other lands are starving to death, there ought to be other motives to compel us to stop this food waste; that is, motives other than dollars and cents.

FOOD PROCESSING RESULTS

In our ignorance in years of plethora of good foods, we have developed practices in food processing and food refining that will cause serious injury to health in times of food scarcity. I refer to such processes as the modern milling of our wheat and rye into white bleached or so-called patent flour. I refer to such processes as are involved in some of our prepared ready-to-eat breakfast foods, prepared in many cases from our good cereal grains under conditions where some of the most important nutrient elements are lost, and the proteins that are left are largely denatured or rendered inferior for human nutrition. The milling of patent flour and the preparation and consumption of these ready-to-eat breakfast foods under our ordinary peacetime variety of an abundance in diet would not be so serious. It is a fact that when the wheat bran from the flour mills is fed to hogs, chickens, and cattle, these get the better part of the grain. It is misleading to add two or three of the vitamins, and a little iron and lime to this denatured flour and call it "enriched," when as a matter of fact, that "enriched" flour or bread is still *impoverished*. When food is abundant, the gray squirrel and the rat eat only the germ of the corn and leave the rest. In our ignorance, we eat the rest and feed the germ to hogs and cattle. I have even heard this argument: that we must not mill more nutrients of the wheat berry into the flour for human consumption, because that will decrease our good cattle feed!

In the pro and con argument for milling more of the normal nutrient of wheat and rye into our wheat and rye flour versus our present program of "enrichment" or our defective patent flour with thiamin, riboflavin, niacin, and iron, one frequently hears that our people will not eat whole wheat or whole rye bread; that our bakers cannot bake a good loaf out of whole wheat and whole rye; and that the American stomach cannot tolerate and digest whole wheat and whole rye bread. Now, what are the facts in the case? Certainly, there are a few people with chronic gastro intestinal hyper-irritability who would be seriously affected by the roughage in whole wheat or whole rye bread. These of course will have to have special diets, like some people afflicted with other types of diseases. But the American stomach and the American palate are not different from the stomach and palate of the people in Northern Europe and Russia, or the stomach and palate of the American Indian who ate whole corn when it was available. In Europe and Russian whole rye bread, and to a lesser extent whole wheat bread, have been human food staples for centuries, possibly for thousands of years. These people grow on it, they travel on it, they work on it, they love on it, they fight on it. I lived on whole rye and whole barley bread, essentially, till I was sixteen years old. The Russian soldier today stands up pretty well and fights rather well on this dietary staple. The American palate and the American stomach cannot have changed or deteriorated so greatly in the few decades or centuries since our forefathers left northern Europe. Human nature does not change that fast. And as to our people not eating whole rye or whole wheat when our customary bread is available, I think they will eat it with avidity, if they are hungry enough. According to Dr. Villijalmur Stefasson, dental caries, and frank vitamin deficiency diseases were not known among the Eskimos until the introduction of our processed foods.

FOOD WASTES

There is one serious waste of good human food which war necessity should compel us to correct. I mean the tremendous waste of skim milk. There is prevalent among us the superstition that the essential food value in milk is the fat thereof; that is, butter. So the saying has come about that when we take the essential value out of a situation or process, we have *skimmed* it. Now as to butter and skim milk, we now know that view is untenable. It is well established that it is false. For skim milk contains practically all the valuable proteins, valuable minerals, and some of the valuable vitamins of whole milk. Now, in our great consumption of butter and cream, the skim milk which is produced goes largely into hogs, chickens, and calves instead of the human stomach; and in many cases into commercial products such as glazed paper and glue not even as significant for our existence and health as cattle, hog and poultry feed. We should not allow this inexcusable waste of a superior human food—skim milk. We would have an additional insurance of good national health through better nutrition did we consume as whole milk, every drop of milk that we can possibly produce. Modern science of chemistry, and nutrition, can now produce a spread for bread essentially out of vegetable fats, a spread for bread nutritionally equivalent to butter. But we pass Federal and State laws to impede and present it.

In countries where the population is up to the point or beyond the number that can be sustained in abundant health by the products of the soil, the people on the whole are more *omnivorous* than we in the United States. They are so by necessity. We tend to look down on people as ignorant, inferior, or degraded, if they consume animal or vegetable products that we (in our ignorance) reject as foods. I am informed that neutral Sweden has put price ceilings on seagulls and crows. There are, indeed, very few cereal grains, legumes, tubers, vegetables or fruits that are in themselves poisonous to man, and there are even fewer such poisonous animals, when killed and prepared as meat products usually are, for human consumption. We could be, and in face of a real food scarcity, will be much more omnivorous than we are now. In fact, I am sure there would be a greater assurance of abundant health through adequate diets were we more omnivorous in times of peace than is our usual habit. Unless the one-sided diet is selected from few of our known superior foods, monotony in diet is apt to spell inferior health, because we do not as yet know everything in regard to optimum nutritional requirements for man either in the field of proteins, amino acids, minerals, or vitamins.

OBESITY

Food scarcity in war time could and should correct at least one type of malnutrition in our country, that is, the eating of good foods to the point of obesity. Obesity is a liability to health. There can be no question about that fact, especially in people 40 years of age or beyond. To be sure, we have no accurate statistics of the prevalence of obesity in our land, but it is my impression that north of the Mason and Dixon line, obesity is far more prevalent than underweight. I think adequate hospital statistics would bring that out. Statistics in the case of one large life insurance company reveals the fact that among its policy holders, obesity (more than 10 per cent above standard) runs 28 per cent, while underweight (more than 10 per cent below standard) is less than half of that, or 12 per cent.

THE VITAMINS

The conspicuous advance in the realm of vitamin chemistry, physiology and medicine in the last 25 or 50 years has led to the Utopian hope that maybe many, if not all, of our common ailments, including inferior energy or "pep," and inferior intelligence, are due to vitamin deficiency and can be cured by the 1944 vitamin pills. So the daily press and the hourly radio diagnoses of human ailments, and prescriptions of what vitamins to take cover the page and fill the air. Is vitamin deficiency the main factor to be dreaded or avoided in our war time food problem? I saw plenty of wartime undernutrition in the war-devastated countries in Europe from the Adriatic to the Polar Circle at the conclusion of World War I. The outstanding, conspicuous food deficiency revealed by that population was deficiency of proteins and calories, resulting in hunger edema, loss of weight, retarded growth in children, and tuberculosis and other infectious diseases. When such foods as milk, eggs, meats, poultry, and fish seriously decrease or entirely disappear; when the cereal grains are denatured by modern milling, protein deficiency is not far away. And since the immune bodies are proteins, and proteins are needed in their production, infectious diseases will rise with the diminuation or disappearance of foods of animal origin and milling the germ out of wheat, rye and corn. The intake of fats will also decrease, and the calorie needs have to be met largely by starch. However, it is not impossible that protein deficiency alone might account for the overall loss in body weight in the children that I saw in war-devastated Europe in 1919. Calories might be adequate, and the condition would still have been as I saw it. At least that is the present indication of animal experimentation. I believe this is an important point to be always kept in mind by the medical profession in advising or guiding governments or patients as to foods and diets in wartime. And there is special responsibility on the shoulders of physicians and nurses in wartime in the matter of special diets for special diseases. Such special needs should be real, not merely traditional, and the special allowances should reach the patient's stomach, not other stomachs.

The recommendations of the Food and Nutrition Committee of the National Research Council nothwithstanding, the fact is that we do not yet know the optimum vitamin needs of man. Our country has been rendered *vitamin conscious* by the press, the radio, and the less critical laboratory and clinical workers in nutrition. The detail man is so eloquent and persuasive that even the most competent and conscientious physician is in a dilemma. Clinical recognition of vitamin deficiency in our populaton is now rare, except for pellagra in the south. Laboratory and clinical tests detecting insipient vitamin deficiency are as yet largely in the experimental stage. But lest we overlook a bet, too many of us jump on the vitamin bandwagon. Even our Councils of Pharmacy and Chemistry, and of Food and Nutrition (A.M.A.) have given provisional approval of the old shot-gun therapy in the form of commercial vitamin mixtures (*J.A.M.A.* 1942, Vol. 119, page 948). There are particular difficulties in connection with the possible needs of vitamin B complex, both in apparent health and in definite disease, since some of these vitamins are important in the proper functioning of the nervous system, such as mental and physical endurance, mental alertness, mental and physical fatigue, etc. And, certainly, we need our brain and our muscles working at highest competency if we are to win this war in a reasonable time. So many tests have been made to find out whether vitamin pills added to the usual diet of people in industry and in offices will increase production and lessen fatigue. That line of work is full of pitfalls because mental fatigue is in part a question of interest in the work at hand, rather than of an adequate diet; and it is further true that increased susceptibility to mental fatigue, from mental and physical work, is present in diseases other than those due to defective diets, although such increased fatigability undoubtedly will follow any chronic deficiency in calories, proteins, and vitamins as well as organic salts. Quantitative determinations of fatigability are full of pitfalls, especially in the uncontrollable psychological factors, and call for so much time, both on the part of the patient and the physician, that this method is virtually out of the question, even in our best hospitals. Merely recording the patient's opinions on his history sheet gives no reliable data to the doctor, and contributes little or nothing to medical advance.

Drs. Holt and Nadjar of Johns Hopkins Medical School have recently reported the important discovery that the usual bacteria in the human alimentary canal manufacture thiamin, in some cases in sufficient quantities to meet the needs of the body, at least for a while, without any of this vitamin being present in the diet. Dr. W. H. Sebrell is probably correct when he says that "almost all practicing physicians are now prescribing vitamin preparations for more and more of their patients." But when Dr. Sebrell adds that "this is significant," I am compelled to ask: significant of what? Direct advertising to laymen undoubtedly sells more and more vitamin pills to these laymen on their own diagnosis of real or imaginary ills. *Neither fact proves the need for vitamin pills for the abundant health of the people.* There was a time when physicians prescribed more and more phlebotomy. The only significance of that fact was lack of understanding of that generation of physicians. If, as some colleagues claim, constipation, irritability, fatigue are nutritional deficiency diseases, it is clear that all of us need additional vitamin nearly all the time, even in peace; that is, if we do any serious work at all. But chewing gum, cigarettes, and Carter's Little Liver pills also promise that needed "lift," that abundant "pep." And how can we neglect that dreadful "acid side" of life, which Alka Seltzer promises to convert to a cheerful bathroom yodle in the morning?

It should be evident to every informed physician that a marked and chronic impairment of hunger and appetite, from any cause whatever, may ultimately lead to some degree of malnutrition, even when plenty good foods are available. Is the reverse also true? Does starvation, does deficiency in one or in all essential food factors, lead to decreased appetite? Some nutrition workers, some otherwise competent physicians say: "yes." This view is largely based on laboratory tests on rats, with diets lacking in the Vitamin B complex, specifically thiamin. But is it true for man, especially in the usual phases of undernutrition, due to food scarcity because of war? My experience with fasting and starving rats, dogs, men, and nations says: *No.* And that is also the answer of general animal biology. If starvation short of death destroys hunger and appetite there would scarcely be left on earth any animal species, for food scarcity has faced most, if not all, of them from time to time for millions of years. The rat for a long time on a diet very deficient in the Vitamin B complex usually eats less and less of that food, but the same rat, unless moribund, will eat more and more of better foods, if he gets the chance. The story has it that Colonel Rickenbacher and his companions ate raw seagulls after some three weeks' starvation. Dogs fasted to such a degree of weakness that they cannot stand and cannot walk will eat, or try to eat, though they may be too weak to swallow. Severely malnourished, that is, undernourished people in the war-wrecked countries in Europe in 1919 ate with avidity, what to most well-fed people would be regarded as very tasteless, impalatable, if not actually disgusting foods. No, failure of hunger and appetite are not early and reliable criteria of wartime malnutrition.

NUTRITION PROBLEMS AND THE PHYSICIAN

But, owing to wartime food rationing, relatively scarcity of some of our good and usual foods, and consequent changes in our usual menus; further, because of the current stress on foods and nutrition, some of it wise, some of it otherwise, the physician will have increasing calls to eliminate or establish undernutrition in his patients. How can he do it? If we shut our eyes and merely prescribe vitamin pills (even with the minerals included) we will, in most cases, render a disservice to our patients, our science, and our country. It is easy to say: first eliminate all other disease. But this is extremely difficult to apply, as malnutrition and other diseases may coëxist. But this, at least, is true: even in the total absence of all other diseases, *significant undernutrition in the child will retard growth and reduce body weight significantly below the average. Significant undernutrition in the adult will reduce body weight much below the normal average.* Of course, edema from insufficient proteins is an exception. We have quantitative measures of body height and of body weight. If we project all other tentative criteria of undernutrition against these factual base-lines, we will render full service to our patients and to our country in the matter of food and war, and we will commit no major sins against science.

Since adult men and women, starting with good average health, can live from 40 to 70 days without any food whatever (including vitamins), it is clear that the minimum food allowance for mere existence is much lower (both in energy and in other essentials) than the minimum ration for reproduction, optimum growth, maximum work, and maximum resistance to infections, assuming comparable climates. But rations providing mere existence are a biological futility. When food sources fall that low, war ends and reproduction should cease voluntarily, in fairness to the mother, the child, and the nation.

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CALIFORNIA'S FOOD PROBLEM IN A WARTIME NUTRITION PROGRAM*

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THE most compelling reason why the medical profession can well afford to take an interest in the food and nutrition program of California, is quite a selfish one. The physician is bearing an excessive burden in caring for the sick. Adding a decreased well-being of patients as a result of malnutrition, makes his burden still heavier.

It is readily understandable why the enthusiastic nutritionist feels that the physician has not shown the interest in the application of food to well-being that present knowledge of nutrition seems to warrant. The nutritionist, however, is apt to overlook the fact that nutrition is a new science, whereas medicine is, by comparison, an old one.

Dr. Frederick J. Stare, of Harvard University Medical School, presented the broad reasons why the medical profession does not yet wholeheartedly embrace the doctrine of "excellent nutrition." Dr. Stare reasons that clinical medicine thinks in terms of disease and pathology, instead of in terms of health, of preventive medicine or long time results.

Another reason, cited by Dr. Stare, is that the physician still lacks objective evidence that optimal nutrition is really a factor of major importance in the run of the mill diseases seen in the general practice of medicine.

The exigencies of war seem to have made America—even blockaded England—a healthy nation, regardless of certain food curtailments.

The answer lies partly in the better use of available foodstuffs, which became an immediate basic consideration in planning and administering a nutrition program when supplies are curtailed by extraordinary wartime demands even in the face of increased production.

FOOD AND NUTRITION

Food and nutrition, unfortunately, are NOT synonymous. Food has always been the most critical of all war materiel. Its abundance "toughens the sinews of war," and, conversely, its lack becomes a powerful solvent for "softening up" the fighting man and the civilian alike. In addition, the nutritionist has a keen appreciation of the relationship of specific food factors necessary to physical well-being. He has seen nutrition surveys showing the high percentage of population not eating a sufficient amount of the proper foods even when they are available. He consequently sees curtailment of meat supplies not only as a threat to protein adequacy, but as a problem of meeting the niacin requirements set up in the "yardstick." His outlook and viewpoint naturally are colored by more meticulous scientific thinking habits, and it often becomes more difficult for him to adapt himself to the broader use of food as sustenance.

Essentially, there is no scientific conflict between a program based on an academic concept of nutrition and a realistic war food program. It is a question of practical approach to the limitations and dislocations of life under wartime conditions. The American fighting man in a foxhole does not get a scoop of ice cream on his apple pie. He does not expect to find either in his K-ration. He does receive the utmost in concentrated calories and essential nutrients to keep him as well-fed as is scientifically possible.

To be a civilian service for the people of California, a nutrition program had to be one to aid the civilian to obtain and utilize the food he requires to satisfy his needs. Basically, a wartime balanced food and nutrition program—whether for California or the entire United States—must call for one founded on foods which are economical sources of nutrients. By economical, is not meant solely the dollar and cent value or price paid by the ultimate consumer, but economy in terms of manpower and other factors, influencing the production and distribution of food.

Wartime food production planning no longer concerns itself solely with total production of calories. It must share fats with the munitions makers for glycerin. It must remember the xerophthalmia in Denmark in 1917 which had exported butter, its food source of vitamin A without providing a nutritional alternate. Critical food gaps must be bridged to prevent, as far as possible, endemic nutritional damage.

Pellagra and scurvy are no less deficiency "end states" in the patient of higher economic level with a perverted appetite than in the poverty-stricken or nutritionally uninformed. Niacin or ascorbic acid know no class distinction in their physiological effects.

BORDERLINE NUTRITION

The physician has the first and most consistent opportunity for viewing the intermediate, as well as the end results of poor nutrition objectively. The work of clinical investigators in borderline nutrition activated the National Nutrition Conference, held in Washington, in May, 1941.

Section IIIa (Public Health and Medical Aspects of Nutrition) met under the presiding chairmanship of Dr. James McLester. Its recommendations to the conference body included the following:

"That efforts be made to stimulate greater interest in nutritional problems among general practitioners, and with this in view that opportunity for post-graduate training in nutrition be made more widely available.

"That medical societies, dental societies, and health authorities be represented in all State and community nutrition committees, and that medical groups take an increasingly active part in organizing, sponsoring, and coöperating in nutrition programs.

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

† Chairman, Food and Nutrition Committee of the California State War Council.

"That medical societies be asked to form nutrition committees for the purpose of disseminating nutrition information through symposia, speakers' bureaus, exhibits, motion pictures, and similar methods."

DIETARY DEFICIENCIES: RÔLE OF THE PHYSICIAN

The practicing physician is in a strategic position, it was pointed out, not only to recognize dietary deficiencies, and to advise the individual patient, but to help guide community planning for nutrition, weaving it, as Dr. Casparis said, "into the fabric of the individual."

Many practical nutritionists, like Miss Frances Stern of the Boston Dispensary, held the view that the medical practice of prescribing vitamin pills, rather than food, is due to two factors: (1) the unwillingness or inability of some physicians to calculate food values properly, and (2) the yielding to the patient's insistence for a vitamin prescription, because it was the "easiest way out."

In summary, Dr. McLester stated, the physician should teach people to eat good food, and in that way prescribe vitamins in terms of food.

Thus it was hoped that the physician would become a most influential force in the nutrition program. As the family's medical advisor he holds the confidence of his patients. The industrial or plant physician likewise is in a position to advise management to provide adequate feeding facilities for employees. He can suggest that competent advice on the technical problems of in-plant service of nutritive foods is readily available through the Federal, State and even local nutrition committees.

SOME CALIFORNIA PROBLEMS IN NUTRITION

The war brought sudden and specific problems to challenge California's original nutrition goals. Almost overnight California became a vast armament plant. War contracts transformed the State into one of the greatest industrial areas in the United States. Workers streamed here to man the assembly lines of shipyards and aircraft plants. The food habits of these newcomers were different, and often inferior in nutrition to those of the acclimated. The wholesale entry of women into industry disrupted food-planning and meal preparation in the home. Agricultural production was dislocated by the transfer of farm workers into industry and the armed forces. Meat shortages occurred in California before they did in other sections of the country. Californians were asked to "share the meat" at a time when there was little meat to share.

Thus, to the informed layman the word "nutrition" became a *desideratum*. To the uninformed laymen nutrition still meant only vaguely "eating the right foods," with no real understanding of what the "right foods" might be. Rationing meant an "opportunity to get enough food," rather than sharing.

California's wartime nutrition program, viewed realistically, became primarily a food program into which all major factors and interests affecting food, and its use, had to be called into action:

1. Food production must not be permitted to lag, whether on the broad acres of agriculture or on the home-plot of the Victory Vegetable Garden. Consequently, "flash surpluses" of perishables, such as cabbage, eggs, onions, potatoes, peaches arise to perplex the consumer who has been warned to expect curtailment of food supplies in war. It means emphasis by the various agencies, assisted by the direct contact the State Food and Nutrition Committee has established with the consumer through local or community food committees, to use such surplus food products in greater quantities than prevailing food habits might normally account for. Encouragement by the physician that the family coöperate with these local programs may not seem "medical advice," but quite directly affects health.

2. Food distribution must be kept as orderly as possible, implemented to meet emergencies wherever and whenever necessary, so that edible food shall not go to waste.

Taste and waste are two very difficult problems in meeting war food requirements. They are, however, hedges against hunger. As belts are tightened, willful waste decreases. Left-over butter pats are harder to find in restaurants today.

3. Food conservation is definitely a part of a wartime nutrition program. Conservation encompasses both the elements of fighting food waste in the home and of preservation, whether by canning, brining, drying, freezing, or whatever method is best suited to its storage with the least loss of nutrients. The home conservation program required guidance and supervision. Many "put up" food for the first time, other newcomers did it for the first time in California without recognition of greater hazards, such as botulism, etc.

On the other hand, California has inherent advantages. It has a twelve-month growing season for many of the protective foods, contrasted with the average of seven months for the rest of the United States.

AN ORDERLY PROGRAM FOR CALIFORNIA

What, then, stands in the way of an orderly food and nutrition program in California?

1. The very prodigality of food resources in the past has led to wasteful practices which have no place in a wartime food economy. Approximately fifteen per cent of the edible portion of the food purchased by the American household is wasted. Elimination of all edible kitchen and table waste automatically would increase the available and already distributed food supplies by 20 to 25 per cent.

2. California's racial food patterns are more complex, because they involve larger segments of our population adhering to original cultures. The food pattern of the Spanish-Mexican, and also the Chinese is more rigid than that of the Italian.

Sudden disturbance of a fixed racial food pattern may seriously upset its nutritional balance. Often the racial pattern is barely adequate, as in the case of the Mexican diet, where a curtailment of beans, either by shortage or high ration-point value, would produce a definitely low protein intake, unless a compensating protein alternative, acceptable to the Mexican palate and culture, were made available. Meat and cheese would become the nutritionist's answer. In the wartime demand for increased meat to meet a bean protein shortage, the food economist would regard the nutritionist's solution as another "let them eat cake!"

The Oriental food pattern is even less understood, although it was the subject for the first nutrition study in California, when Atwater published his nitrogen balance studies on Chinese laundry workers and a family of Occidental "fruitarians" at the turn of the century.

The Italian pattern is more flexible. It permits adjustments in the light of projected food supplies, other than cheese, in California. Cheese, on the other hand, is of no concern to the Oriental pattern of which it has never been a part.

These and many other factors enter into a nutrition program, and must seem strange to those accustomed to looking on nutrition through the lens of the laboratory microscope. Nevertheless they are real. They have become part and parcel of an orderly program for adequately feeding our California population.

They further constitute individual problems, one of which may exist only in San Mateo or Vallejo, and another which affects Riverside. There can be, unfortunately, no *fixed* Statewide program.

PUBLIC EDUCATION

The alternative, therefore, is public education in food problems and food use for nutrition. For such a program intelligent leadership is needed, because food science in terms of nutrition is still new. Education requires the willingness of those-who-know to pass sound information on to those-who-need-to-know. The physician will be "one who is asked," as the public's interest grows more pointedly "technical."

The public, however, must not be confused by technical knowledge and rapidly-changing scientific findings of great interest to the nutritionist alone. To convey pertinent and helpful food facts requires organized discussion-groups, headed by competent leaders. To put the facts, so learned, into actual practice in the form of nutrition requires discussion leading to group-decision "to do something about it." Research in nutrition teaching methods show that there is no comparison between the "cold" lecture method and the group-discussion-with-decision method when it comes to tabulating the results in the form of improved food habits in a community.

Trained individuals will be needed for leadership in their communities to determine the most pressing nutrition problem in the community, whether it be a nutritionally unbalanced school lunch or the establishment of in-plant feeding in a crowded war industry, and then to aid in solving the problem. Translated into actuality it means the maintenance of an authoritative food information and nutrition committee in every community. In most communities local food and nutrition committees have been formed, working on local problems. Some, unfortunately have had to carry on with little or no participation by the physicians of the community.

Poor health, resulting from malnutrition, these physicians argue, is a matter of individual concern until it is severe enough for the physician to repair the damage. Infant health and maternal welfare are now shown to be so benefitted by sound prenatal nutrition advice that this position must seem untenable even to the layman.

San Bernardino County's nutrition objective centers around just such a coöperation between its medical society and the community committee in a prenatal nutrition advice program.

Programs, such as these, bridge the gap between dietetics, as practiced by the clinician who is treating the diabetic or the obese patient, and his teaching the use of food by the well-patient who will soon be called upon to undergo more than normal demand on her metabolic processes. It emphasizes, too, the need for real nutrition courses in medical schools, not merely for pediatrics, but for obstetrics, surgery and general medicine.

Such basic training will enable the physician to judge better between the overenthusiasm, bred by the newness of nutrition, and the ultra-conservatism so obvious from the almost stereotyped "W D and N" (well developed and nourished) on so many clinical diagnosis charts.

1610 Comstock Avenue.

Landry's Paralysis.—In 1859, in a well-arranged report entitled, "Note sur la paralysie ascendante aiguë," the French physician, Jean Landry, gave his original description on the acute ascending spinal paralysis. Since then this disease has justly borne his name, and today still is recognized as a clinical entity. It is a rare disease in which the paralysis is sometimes descending instead of ascending.—Warner's *Calendar of Medical History.*

WHAT CONSTITUTES A NORMAL DIET*

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A NORMAL diet provides all essential nutrients, bulk and fluids, in sufficient amounts and suitable form, for growth and repair of tissues, energy needs, and regulation of body processes.

THE PHYSICIAN'S RESPONSIBILITY

Since people look to their doctor for advice and guidance on family problems, he has the opportunity to impress upon the homemaker the tremendous importance of her position as it relates to the family health and happiness. She should be advised that she has a real opportunity and a challenge; she must have the imagination of an artist in planning attractive meals, the cleverness of a showman to present an adequate diet to a family with various food likes, the economist's knowledge of supplies and shortages, and the food chemist's knowledge of food preparation to retain values. The successful homemaker today takes her place with other soldiers of production. She should be entitled to recognition for outstanding accomplishments. If the doctor has the coöperation of a family, fed by a mother who fulfills these "specifications," he will have no cause for concern over a normal diet for the family.

A NORMAL DIET

In order to conserve space, practical information concerning the requirements of a normal diet, conservatively estimated from reliable sources, using commonly-available foods in acceptable portions, is presented in tabular form with a minimum of explanation.

Recommended daily allowances for calories, protein, calcium, iron, and specific vitamins are tabulated for men and women by activity, and for children by age groups, by the Committee on Foods and Nutrition, National Research Council.

The Basic Seven Classification of Foods† is accepted by nutrition authorities as a simple means of presenting general information on a normal diet. It is used to interpret the Recommended Daily Allowances for Specific Nutrients for various members of a family group in terms of household measurements, in Table 1.

ANALYSIS OF INDIVIDUAL'S DIET

The first six groups and amounts suggested in Table 1 meet a little more than the basic caloric needs—they meet also the protein, mineral, and vitamin requirements. They outline the fundamental diet considered essential to health for each individual. This outline may well be used as a guide in checking adequacy of food intake as a part of physical examinations. It is the foundation upon which therapeutic diets are built. Group 7—Fats—provides calories and makes possible a more concentrated diet, especially important for those with small food capacity; it also adds more Vitamin A. The Riboflavin content of the diet in Table 1 is on the borderline, unless special attention is paid to choice of individual foods.

RICH FOOD SOURCES OF PROTEINS, VITAMINS, AND MINERALS

Because everyone does not select his diet carefully, or may not tolerate certain foods, good food sources of proteins, vitamins, and minerals are listed to assist in the inclusion of adequate amounts of specific nutrients.

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Nutrition Department of the Los Angeles City Health Department.

† See the National Wartime Food Guide, U. S. Dept. of Agriculture, War Food Administration, Washington, D.C. (Form NFC-4 Rev.)

Protein.—The protein recommended for the average male adult is 70 grams, or one gram of protein per kilogram of body weight. Each food listed in Table 2 contains approximately 7 grams of protein. One-half of the protein should be chosen from animal sources. Ten portions meet the daily protein need. A man may obtain his recommended protein intake by eating the protein-rich foods noted in the one-day's diet shown in Table 3.

Vitamins.—Vitamin A, recommended for the male adult, is 5,000 I.U. per day. Vitamin A (pro-vitamin A) is found in dark green and yellow vegetables, and is fairly stable. At least one serving of leafy green or yellow vegetables, plus some animal source of Vitamin A, should be included in the daily diet to assure requirements.

Vitamin B.—Food sources, commonly available, of three members of the B Complex, for which allowances have been recommended in the human diet, are shown in Table 4*. Average servings of edible portions of foods are given, with no allowance made for cooking losses. Note (from chart) that the addition of brewers' yeast and wheat germ may greatly improve the average diet.

Vitamin C.—The male adult allowance of 75 mg. per day may be obtained from one large orange, 5 oz. of orange juice, or ⅝ of a large, raw, green pepper. One-half to two-thirds is contained in ½ medium grapefruit or cantaloupe, 2-5″ stalks of broccoli (steamed). An average serving of tomato, raw cabbage, potato (cooked in jacket), or cauliflower will provide 1/3 of the day's need.

Citrus fruits, tomatoes, or large raw salads are daily essentials in the diet, otherwise great care must be exercised in selection and preparation of foods of lesser value. A large serving of citrus fruit, or glass of tomato juice and a raw salad provide Vitamin C for the day.

Minerals.—Calcium allowance for male adult is 0.8 grams per day. This may be met with 1 pint of milk, plus 1 ounce of cheddar cheese, or ½ cup of cooked greens. (Turnip, mustard, collards, kale, or broccoli). Oranges, dried figs, canned salmon with softened bones, beans, and corn tortillas are fair sources of calcium.

A diet of beans and tortillas may provide calcium and phosphorus in proper ratio, and also sufficient calcium when eaten in large amounts. However, it may lack essential amino acids and other vitamins found in milk. Therefore, special emphasis should be placed on cheese and green vegetable additions.

Iron.—Iron allowance for male adult is 12 milligrams per day. From the iron-rich foods (each containing 1½ mg. of iron) listed below, choose daily at least 8 portions for men, women, and children over age 7; 10 portions for adolescent boys and girls; 10 portions for pregnant women.

⅔ oz. liver; 2 oz. lean meat; 1 egg
⅔ cup cooked oatmeal; 1 cup whole wheat or cornmeal
3 slices whole grain or enriched bread; 3 cups milk
2 tablespoons wheat germ; 1 tablespoon molasses
3 halves apricots; 4 prunes; ¼ cup raisins (seeded)
7 dates; 4 small dried figs; ½ medium avocado
½ cup cooked greens (beet tops, chard, kale, mustard)
½ cup cooked dry beans; ½ cup peas; 1½ medium potato

Instead of taking 10 separate items from suggested list, one may use several portions of one food, such as 3 ounces of liver (which would give half of the day's allowance), and to this should be added 2 servings of green vegetable, ⅔ cup of oatmeal, and 1 tablespoonful of molasses or 2 tablespoonsful of wheat germ. A varied diet using foods, in natural state, usually assures sufficient iron and copper, the latter being a dietary essential which is associated with iron in food.

Know How to Get the Maximal Values Out of Foods. Vitamins, mineral, and protein values may be reduced or destroyed by heat, light, air, and water. Therefore, the physician should make available to his patients, confused by information from unreliable sources, the changing information on retention of values and selection of foods, which continuous research is bringing to light. Since the busy physician, who has no dietitian in his office, has little time to evaluate this changing stream

TABLE 1.—*Practical Interpretation of the Normal Diet for Individuals in the Family Group Using Basic 7—Classification of Foods**

Food Group	Food	Moderately Active Man (154 lbs.)	Moderately Active Woman (125 lbs.)	Pregnancy Latter Half	16-20 Year Old Boy	13-15 Year Old Girl	10-12 Year Old Child	4-6 Year Old Child
I	Green and yellow vegetables...	½ cup	½ cup	1 to 1½ cup	½ cup	½ cup	½ cup	¼ cup
II	Oranges, ½ grapefruit, tomatoes, cabbage, green salad.....	1 med. or large serving raw	1 med. or large serving raw	1 med. plus large serving raw	1 med. plus large serving raw	1 med. plus salad	1 med. plus salad	½ med. plus small salad
III	Potatoes	1 medium	1 medium	1 medium	2 medium	1 medium	1 medium	½ medium
	Other vegetables	½ cup	½ cup	½ cup	½ cup	½ cup	½ cup	¼ cup
	Other fruits	1 serving	1 serving	1 serving	1 serving	1 serving	1 serving	½ serving
IV	Milk to drink or milk in food..	1 pint	1 pint	1 quart	1 quart	1 quart	¾ quart plus 1 oz. cheese or milk dish	¾ quart plus small milk made dish
	Cheese			Am. 1 oz.				
V	Meat, poultry, fish, eggs, dried beans, peas, peanut butter, nuts	½ lb.	⅜ lb.	⅜ lb.	½ lb.	⅜ lb.	5 oz. or 5/16 lb.	3 oz. or 3/16 lb.
VI	Bread—whole grain	2 slices	1 slice	3 slices	3 slices	2 slices	2 slices	2 slices
	Bread—enriched	3 slices	2 slices		3 slices	1 slice	2 slices	
	Cereal—whole grain	⅔ cup	⅔ cup	⅔ cup	1½ cup	⅔ cup	⅔ cup	⅓ cup
VII	Butter or fortified margarine..	3 oz. or 6 T.	2 oz. or 4 T.	3 T.	3 oz. or 6 T.	2 oz.	2 oz.	1 oz.
	Fats in cooking or salads.....	from VII	from VII		from VII			
Extras as choice or for calories	Sugar or Sweets..............	1 to 2 T.	1 to 2 T.	1 to 2 T.	2 T.	1 T.	2 T.	1 T.
	Desserts—as pie, cake Pudding, Ice Cream, or preferably extra fruits........	1	1	1	2	1	1	
			Extra green vegetable		Extra ice cream or milk dessert			

T=Tablespoon

This table gives specific amounts of food to meet B complex requirements without cooking losses. Therefore add extra B values in extra calories selected.

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* Due to limitation of space Table 4 has been omitted. One may secure Table 4 by writing to the author.

of information on research in foods, as to methods of preparation and practical use, he may check occasionally with the nutrition division of the local or State health department, or the extension division of the State college of agriculture, for unbiased interpretation of the trends.

A few examples are: The potato steamed in its jacket might often replace the baked potato prescribed for infants; the family oatmeal may be strained for the baby; the whole orange may be eaten instead of juice, when conditions permit; evaporated milk may be used in cooking and concentrated diets; utility cuts of meat may be prepared in a palatable manner.

Table 2.—*Foods Which Contain Approximately 7 gm. of Protein (1/10 of the Daily Allowance for an Average Adult)*

Animal Proteins	*Vegetable Proteins*
1 glass milk	½ cup dried beans cooked
1 oz. cheese	
1 egg	2⅓ slices bread
1¼ oz. meat	1 oz. nuts
1¼ oz. fish, poultry or rabbit	2 T. peanut butter
	⅔ cup cooked cereal

Table 3.—*Foundation Menu Providing Daily Protein Allowance for an Average Man*

Breakfast	*Lunch*
Cereal—⅔ cup	Sandwich (with filling of meat, fish, cheese, nuts or eggs) or
Bread—2 slices	Beans—½ cup and bread—2 slices
Egg—1	Milk—1 glass
Milk—1 glass	

Dinner

Meat—¼ lb. (good serving **Bread—1 slice**

Total—71 gm. protein.

Careful Daily Selection to Provide Normal Diet.—Increased income has brought a wider use of luxury—and out-of-season foods, with a frequent poor selection of certain essential foods. It is important to stress, from childhood, the use of a wide variety of foods within each of the seven groups, in order that the various minerals and vitamins that are minute in quantity, be incorporated in the daily diet. For optimal nutrition, the calories should be chiefly provided from foods in their natural state, instead of great amounts of highly-refined starches or sweets. Without a daily consumption of a green or yellow vegetable, a citrus fruit, two or three other fruits or vegetables, a pint of milk, some animal protein, some whole grain cereal, a normal diet will not be attained. Diversion from this dietary pattern, over a period of time, may require correction for deficiencies that may result.

Los Angeles City Health Department, 116 W. Temple St.

Physician Decries Vitamin Buying.—Spending by American people of $25,000,000 this year on vitamins is a deplorable waste of money, in the opinion of Dr. Herman L. Kretschmer of Chicago, president of the American Medical Association, recently in Denver for sessions of the Colorado Medical Society.

"Very few people in this country suffer from vitamin deficiency," Doctor Kretschmer said. "Such deficiency diseases as scurvy, rickets and pellagra have been almost wiped out."

He added that he did not want to decry the magnificent achievements that have been made in recent years by vitamin chemistry, but added, "I think it is ridiculous for people to expect radio announcers and grocerymen to prescribe for their health."

According to Doctor Kretschmer, vitamins should not be taken indiscriminately, but under a doctor's orders.

HOW TO MEET THE NEEDS OF THE NORMAL DIET WITH RATIONING OF FOOD[*]

Flora Rose, D.Sc.
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A brief survey of the present food picture, as a whole, and of the problems it presents, is necessary if ways are to be found for meeting this issue satisfactorily.

First. Among the foods now rationed, or of which there is a threat of shortage, are milk, cheese, meat, and canned and frozen fruits and vegetables. Careful thought needs to be given to the means of compensating for nutritive losses which may result from the necessity for reduced consumption of these foods, all of which belong to the group of "protective" foods.

Second. The foods of which there is promise of abundance are the grains and grain products, such as bread and cereals and the dried legumes. This means that the extension of their use may be accepted as a necessity. It means further that dependence may need to be placed on grains and legumes to replace, insofar as possible, nutritive values lost in reduced consumption of milk, cheese, eggs and meat. They will also help replace shortages in fats and sugar. Grains and legumes should now be scrutinized for their "protective" qualities, and careful consideration must be given to the kinds of cereals which are available, and to the methods by which they have been refined or prepared.

Third. Essentially all forms of fat are now rationed. Butter may and will become increasingly short if the milk supply is to be protected. The loss of Vitamin A normally consumed in a good grade of butter will be covered if margarines, reinforced with Vitamin A, continue to be available in reasonable amounts. If, because of their lower point values, fats other than butter are selected by the consumer, the intake of plant-rich sources of provitamin A, or carotene, must be increased if the Vitamin A allowances are to be met. The consumption of fat-rich foods, such as peanuts and peanut butter, and soy beans and nondefatted soy bean products, may need to be increased in the diets of manual workers if the program of three meals a day commonly followed in this country is to furnish the energy required by them at reasonable cost. Furthermore, scraps of meat fats often wasted in the household must be conserved, and ways must be sought for using them. Homemakers must learn to render, to clarify and to make savory and acceptable all fats which reach the household.

Fourth. Serious threats to the adequacy of many diets result from the rationing of canned and frozen fruits and vegetables, and the cost of many fresh fruits and vegetables. Every encouragement should be given to the purchase of those fruits and vegetables which are of greatest nutritional value. Victory garden and home-food preservation programs should be urged.

Fifth. The rationing of sugar has been beneficial rather than otherwise, for the nutritional values of sugar are limited almost entirely to calories and seductive flavor. Increased use of grains and legumes may compensate for the loss of calories from sugar, and may contribute other important food values as well.

OBJECTIVES IN ACHIEVEMENT OF A NORMAL DIET

In the effort to achieve a normal diet in the face of shortages of many common foods, there are three objectives to which special attention needs to be given. In large part, a satisfactory solution of the problem of good nutrition centers in them. These objectives are to provide sufficient protein of good quality; to furnish adequate amounts of minerals, particularly of calcium; and to supply a diet high in all essential vitamins, particularly Vitamin A and riboflavin.

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[*] One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the College of Home Economics, Cornell University, and Department of Nutrition, Berkeley Public Schools, Berkeley, California.

Perhaps the most immediate problem is that of supplying an adequate amount and quality of protein. The new knowledge of nutrition emphasizes the importance not only of a reasonable total daily consumption of protein, but also the significance of the quality of protein. Protein foods are being rated as good or poor in quality in terms of their amino acid content. Specifically, this means that proteins are rated according to the amounts of each of the ten "essential" amino acids contained in them. A goal in the attainment of normal nutrition, therefore, is to include in the day's meals those foods which will furnish the needed abundance of good quality protein. Animal foods, milk, cheese, eggs and meat, all contain proteins of superior quality. The major plant sources of protein, grains and legumes supply proteins of lower quality than those of animal foods.

One situation which gives the nutritionist growing concern is the poor quality of protein in those grain foods which have been highly milled or impoverished, and especially of the white bread in common use in this country. The removal of the germ and aleurone layer from wheat in the manufacture of white flour takes from wheat its proteins of highest quality, proteins in themselves of value sufficient to provide for moderate growth and good maintenance, and leaves behind only proteins of poor quality. In addition, by far the larger part of the minerals and vitamins of wheat are also lost in this process. In this period of food shortages, the enrichment of flour through the addition of three vitamins and one mineral does not entirely compensate for the losses of proteins of high quality, or of some of the other twenty-five or more nutrients largely concentrated in germ and bran, which are sustained in the milling of white flour. Ordinarily this might not be serious. Now, however, it can assume such proportions as to cause actual physical deterioration. The use of whole-grain products is therefore, from the point of view of the quality of protein alone, of great importance at a time when the availability of animal protein foods is restricted. While dried legumes as a whole are richer in protein than grains, the quality of their protein content is inferior.

Wheat germ and debittered brewers yeast, if available, are both sources of proteins of good quality.

The second objective in which the maintenance of a normal diet may be threatened is in the supply of needed amounts of various minerals, particularly of calcium. While a possible deficiency of calcium is, theoretically, simple of solution, actually this may not be the case. Calcium is very unevenly distributed in foods, milk being the only food containing sufficient calcium to meet optimal calcium needs on any practical basis. Curtailment of milk in the diets of growing children, pregnant women and nursing mothers may seriously hamper the development and health of both child and mother. Deficiency of calcium in the diet of other adults, though less spectacular, in effect is also a health hazard. Calcium may easily be included in the diet in one of the many inorganic forms on the market, but understanding of the need for calcium and of this method of meeting it is not general, and should be greatly extended if milk consumption is reduced.

The third field in which there is a possibility for dietary deficiencies during rationing concerns itself with vitamins. Vitamin A may be much reduced in the diets of those persons who have depended largely on milk, cream and butter as its source. Increased use of the green and yellow fruits, and vegetables which are rich in the precursor of Vitamin A, carotene, may be relied upon, however, to overcome this shortage.

The food, whose common use in recommended quantities has been the most important dietary source of riboflavin, is milk. Next in importance, though not comparable in total amounts consumed, have been meats of all kinds and some vegetables. White flour has been enriched in riboflavin until it exceeds whole wheat products in this one respect. However, this difference becomes negligible in solving the problem of the riboflavin content of the diet as a whole. This may mean giving special consideration to all other available foods of good riboflavin content besides milk, meat and whole grains. Soy beans, peanuts, lima beans, eggs, broccoli, green peas, spinach and possibly other greens, sweet potatoes, wheat germ, dried yeast, are good sources of riboflavin.

Increased use of whole grain products and of legumes will do much to restore to the diet material amounts not only of thiamin, riboflavin and niacin, but of some other known members of the Vitamin B complex and possibly others suspected but not identified.

If citrus fruits and tomatoes are scarce or expensive, the Vitamin C content of the diet may be kept high through the use of foods such as raw yellow turnips (rutabagas), raw green cabbage, raw soy bean sprouts, and fresh fruits or raw vegetables as a whole. Potatoes, eaten in quantity, may make a valuable contribution of ascorbic acid, but must be supplemented with other sources of this vitamin.

SUMMARY AND CONCLUSIONS

There is no basis for apprehension on the part of the people of this country that their food needs may not be met on a reasonably normal basis. If, however, the needs of a normal diet are to be met with rationing and restrictions of foods, greater understanding of food values will be necessary, food habits will have to undergo modifications, food choices must be made thoughtfully, and home food production and preservatiion of food must be increased.

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THE PHYSICIAN AND THE OPA IN THE MANAGEMENT OF PATIENTS REQUIRING SPECIAL THERAPEUTIC DIETS*

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THE advent of food rationing has placed upon the medical profession the serious responsibility of prescribing food for persons who, by reason of impaired health, must have more of certain scarce foods than their allotment of ration points permits them to purchase. Recognizing this necessity, the Office of Price Administration authorized physicians to issue prescriptions for such foods in such quantities as the attending physician deemed necessary. Experience to date has shown that the great majority of physicians have taken this responsibility seriously and, recognizing the necessity for rationing, have been most circumspect and conservative in issuing food prescriptions. A very few physicians, however, have prescribed food in quantities which seemed excessive or occasionally without sufficient medical justification. It has been necessary to establish certain controls because of this very small percentage of the total number of physicians. The method usually followed by the Office of Price Administration has been to request local medical associations to designate committees of physicians who, acting as an advisory committee, examine food prescriptions and advise rationing boards as to whether or not the prescriptions are proper and reasonable.

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Office of the Medical Advisory Committee to the Los Angeles O.P.A.

The reader's attention is invited to the article entitled, "Food Rationing in Wartime," which appears on Page 422 of the October 16, 1943, issue of the *Journal of the American Medical Association*. It should be read by every doctor who prescribes food.

RECOMMENDATIONS OF NATIONAL RESEARCH COUNCIL

The Subcommittee on Medical Food Requirements of the Committee on Drugs and Medical Supplies of the Division of Medical Sciences of the National Research Council to the War Food Administration has prepared certain recommendations, setting forth the maximal allowances of rationed foods which, in the committee's opinion, should be prescribed for patients suffering from certain diseases, such as diabetes mellitus, tuberculosis, nephritis, cirrhosis, colitis, chronic suppuration, and sprue. The subcommittee based its recommendations upon opinions sought from recognized authorities on metabolic diseases and internal medicine throughout the country. There was much research and correspondence before this report was submitted. A typical recommendation is that for diabetes mellitus:

"Provisions for patients with diabetes mellitus may need to include per week not more than: meat, including fish and poultry, 64 ounces; bacon, 8 ounces; butter or margerine, 16 ounces; other fats and oils, 7 ounces; eggs, 7; milk, adults, 7 pints; milk, children to age 16, 7 quarts; fruits and vegetables, 72 ounces. This allowance applies only to processed fruits and vegetables. It does not indicate total carbohydrate requirements. If these amounts of food are not available to the patient from the rationed foods to which he normally would be entitled together with commodities obtainable from unrationed sources, sufficient supplementary ration points should be allowed to provide them."

OPA FORMS

Application for additional food allowances is made by the patient on OPA form R-315. An addendum to the application is executed by the attending physician, who is required to state the exact pathological condition which justifies the prescription; that the patient's health depends upon the consumption of such food, the reasons therefore, the amounts and types of foods required per week for not more than 10 weeks, and the reason why unrationed foods of similar type or nutritional content cannot be used. Processed food should be prescribed only when fresh products are unobtainable, or, for an adequate reason, cannot be used.

Physicians who use accepted scientific criteria in estimating the requirements of patients for whom they prescribe food will encounter no difficulty in having their prescriptions filled. The total amount of food lost through indiscriminate prescribing is perhaps trifling when compared to the total volume of food consumption, but it nevertheless has a serious effect on public morale. Moreover, the physician who yields to pressure and prescribes excessive quantities exposes himself to serious criticism, both of his motives and of his knowledge of dietetics.

429 North Orange Street.

"There is nothing more tragic than the murder of a big theory by a little fact, and nothing is more surprising than the way in which a theory will continue to live long after its brains have been knocked out."—*Thomas Huxley*.

SIGNS AND SYMPTOMS OF EARLY NUTRITIONAL DEFICIENCY*

Lt. Comdr. Dwight L. Wilbur, MC-V(S)-U.S.N.R.
San Francisco

Every wise clinician is continually on the lookout for vitamin and nutritional deficiency diseases among the patients he sees, and not infrequently he may become conscience-stricken for fear that he is not recognizing deficiency states. Physicians and laymen have so often heard that symptoms, such as chronic fatigue, irritability, nervousness, lack of energy and pep, and a host of other frequent and nonspecific complaints, are the result of "not enough vitamins" that with them "hearing is almost believing." The public also is constantly reminded by specialists in advertising that those who partake of this or that vitamin-containing food in adequate amounts will overcome these common symptoms and find a Utopia of health. Obviously the public, and even the physician, becomes confused eventually, particularly because of the lack of clearcut symptoms and signs of early nutritional deficiency.

DEFINITION

A nutritional deficiency disease is a condition which arises when man or animal fails to obtain or to utilize a physiologically-indispensable amount of one or more of the essential nutrients.

THE NATURE OF NUTRITIONAL DEFICIENCY DISEASES

For the purpose of a clearer understanding of nutritional deficiency diseases and the difficulties which arise in recognition of them, it is helpful to consider the relationship between the intake and utilization of essential nutrients and the state of health. This relationship is illustrated by the diagram of Figure 1, and in Tables 1 and 2. Emphasis should be placed on the well-established fact that there is an optimal level of requirement of the various nutrients, and that, other things being equal, the regular intake and utilization of an optimal diet will lead to and be associated with what has been called buoyant health. The optimal level for all the essential nutrients has not been established, but figures have been widely accepted for many of them. There is good reason to believe that an intake of vitamins and minerals in excess of the optimal amount of each will not result in a condition of "super health," and that such excess amounts are either destroyed, eliminated or occasionally stored in tissues.

Further observations indicate quite definitely that there is also a minimal or physiologically-indispensible level of requirement for some if not all of the essential nutrients. When such a minimal level of requirement of one or more of these substances is satisfied, the resulting state of health of the animal or man may be said to be passable, and evidences of deficiency will not be apparent by ordinary clinical observation. (It is possible, of course, that quantitative study of chemical function might indicate a slight abnormality in certain enzyme systems under these circumstances, but for practical purposes such a possibility can be ignored at present).

Furthermore it is quite apparent that there is a wide zone between the optimal and minimal levels of requirement, as illustrated in Figure 1, although the figure is diagrammatic, because of lack of information concerning the amount of the difference between these two levels of requirements.

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

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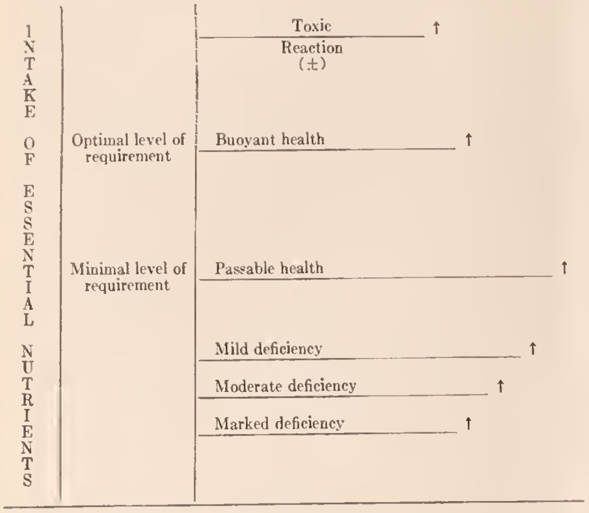

Fig. 1.—Intake of essential nutrients. Effect on health.

Whenever the intake or utilization of an essential nutrient falls below the minimal level of requirement for the substance, a deficiency of it may be said to exist. So far as we know, the first manifestation of such a deficiency is one of tissue depletion. Subsequently, with continuance of tissue depletion or further decrease in intake or utilization of the substance, a "biochemical lesion" may develop. Greater deficiency will lead to functional changes in the tissues, and subsequently, to anatomic lesions. While the distinction between these stages of deficiency is not always definite, and anatomic lesions are probably invariably accompanied by chemical, physiologic or functional changes, none the less this concept is of great value in understanding degrees of nutritional deficiency and the exceedingly rapid or slow response of deficiency states to treatment. Biochemical lesions and functional changes may very rapidly be reversed, following treatment, while anatomic changes are only slowly or incompletely reversed.

Deficiency states of *marked degree* depend on definite and usually extensive pathologic changes in the tissues, and they are usually represented by well-recognized clinical conditions, such as beri beri, pellagra, rickets, scurvy, and nutritional edema.

In a second group may be placed those conditions which usually are due to a deficiency of *moderate degree*, such as the peripheral neuritis of alcoholism, nutritional night blindness, certain types of macrocytic anemia, and glossitis. In these cases the deficiency is less marked than it is in those of the preceding group, and the symptoms depend on physiologic and pathologic changes of a less extensive degree.

In a third group may be placed those conditions in which the nutritional deficiency is of *mild degree*, and in which the deficiency state depends principally upon physiologic and chemical abnormalities, and perhaps upon slight anatomic changes in the tissues. In this group of cases the clinical manifestations usually are less specific than those of the other groups, or are nonspecific, and, as will be pointed out subsequently, represent the principal diagnostic problem in the clinical phase of nutritional deficiency.

RECOGNITION OF EARLY NUTRITIONAL DEFICIENCY

Because the essential nutrients probably are necessary for the function of all tissues and organs, diseases produced by deficiency of them may lead to a large variety of lesions and symptoms. This is clearly indicated if a tabulation is made of the lesions resulting from deficiency of the vitamins (Table 3). However, our concern in this discussion is not with well-balanced and fairly easily recognizable conditions of nutritional deficiency, but with the early signs and symptoms which may accompany deficiency of them. These early general symptoms and signs are usually vague and indefinite, although at times symptoms which are characteristically those of a deficiency of a single vitamin or other nutrient may appear to be the initial and outstanding ones early in the course of the disease.

Table 1.—*Vitamin Intake Effect on Health and Tissues*

VITAMIN INTAKE Level of Requirement	STATE OF HEALTH	TISSUE CHANGES
Optimal	Buoyant	Tissue Saturation
Minimal	Passable	Tissue Depletion
		Biochemical Lesion
Deficient	Deficiency Disease	Functional Changes
		Anatomic Lesions

A sense of fatigue or lack of energy, inefficiency and mental irritability, mild anemia, simple disorders of the digestive tract, and symptoms and signs referable to faulty growth, to the nervous, blood-forming, and reproductive systems, and to the skin, have been considered by Minot as early general symptoms of nutritional deficiency states. More recently, a subcommittee of the National Research Council has listed the signs and symptoms definitely suggestive of such conditions. (Table 4).

It cannot be too strongly emphasized that these early symptoms and signs are not specific for nutritional deficiency, as they occur also in the early stages of many other diseases. The reason for the vague and nonspecific nature of these symptoms can well be appreciated when one considers that, in the early stages of nutritional deficiency, the lesion produced may not only be a biochemical or physiologic one, with slight if any anatomic changes, but it may be widespread and not produce characteristic specific dysfunction of a single organ or tissue in the body.

Table 2.—*The Character of Nutritional Deficiency States*

Degree of Deficiency	*Clinical Signs*	*Essential Changes*	*Incidence*	*Diagnosis*
Marked	Classical deficiency disease	Extensive pathologic	Rare	Clinical findings
Moderate	Variable Definite	Pathologic and Physiologic	Occasional	Clinical findings Laboratory tests
Mild	Non-specific or absent (Preclinical?)	Physiologic Chemical	Common	Laboratory and Therapeutic tests

It is obvious that a diagnosis of a nurtitional deficiency state cannot be made alone on the basis of the symptoms noted in Table 4; in fact little more than a suspicion of the condition can be stimulated by the presence of them. The next logical steps in establishing the diagnosis include a search for symptoms which are specifically those of deficiency of one or more of the vitamins or other substances, and to secure information in regard to adequacy of the previous diet, the function of the gastrointestinal tract, the use of alcohol, and evidence suggesting the occurrence of an infection, of pregnancy, or of hyperthyroidism. Naturally, the physician will make every effort to eliminate other causes for the symptoms, particularly nervous exhaustion, psychoneurosis, tuberculosis, rheumatic conditions, and other functional and organic diseases.

What more specific means than the evaluation of these clinical factors can be useful in establishing the diagnosis of an early nutritional deficiency? In general there are two. The first has to do with chemical determinations of the values for vitamins or other nutrients in the body fluids and tissues, of tolerance tests and of biologic tests, such as the biophotometer test. The second has to do with a therapeutic test consisting of administration of an optimal diet, or of one or more of the various food factors, and observation of the effect of them on the symptoms or signs suspected of being the result of a deficiency state. By some experts an analysis of the previous diet, the dietary history, of the patient has been used as an index of nutritional deficiency. An accurate dietary history is very difficult to obtain, usually requires a skilled social worker, is expensive and consumes a good deal of time, and is therefore not practicable for the average physician.

Table 3.—*Lesions Observed in Vitamin Deficiencies (Modified after Haden)*

Nervous System:
  Peripheral neuritis: paresthesias, pain, weakness, paralysis.
  Cerebral: mental disturbances, psychosis, psychoneurotic manifestations.
  Degeneration of spinal cord: chiefly lateral and/or posterior column.
  Disturbance in function: tetany.
Alimentary Tract.
  Symptoms: Anorexia.
  Secretory disturbances: achlorhydria, loss of specific ferments.
  Motor disturbances: diarrhea, loss of tone and motility.
  Pathologic changes in tissues: stomatitis, glossitis, strophy of tongue, ulceration of intestine.
Cardiovascular System.
  Nutritional heart disease.
  Edema.
  Easy bruising: Hemorrhage.
Skin and Other Epithelial Tissues.
  Scaling, keratinization, dermatitis, strophy, pigmentation, ulceration.
Hematopoietic System.
  Macrocytic, hypochromic, microcytic anemia.
Eye.
  Disturbance in function—night blindness.

The simplest and best therapeutic test in the diagnosis of a nutritional deficiency is the administration of an adequate diet. Many patients with the symptoms previously noted will show striking improvement in health as well as disappearance of symptoms when an adequate diet is made available and followed. Such an adequate diet is patterned on the Recommended Daily Allowances for Specific Nutrients. (See Table 1, Article by Hardgrove, Grace, on page 287.)

Occasionally it may be desirable, especially when signs of specific deficiency are present, to supplement such a diet with concentrates or synthetic preparations of the vitamins. Vitamin A in doses of 25,000 to 100,000 U.S.P. units, as fish oil, components of the Vitamin B complex, as wheat germ or powdered brewers' yeast in doses of 25 to 50 gm., ascorbic acid in large amounts of citrus fruit juices or in doses of 200 to 1000 mg., generally should produce a rapid therapeutic response in patients whose symptoms are due to deficiency of vitamins. In so far as possible, it is well to avoid the continued use of such substances for periods beyond one month; for if relief of symptoms has not occurred in that time, it is highly unlikely that they are due to deficiency of vitamins. The parenteral use of preparations of vitamins in patients of this type is rarely necessary and generally is needed only when there are gastrointestinal disturbances of considerable degree, and for purposes of the psychic effect of an injection treatment. In an occasional case only are the substances effective when parenterally administered to patients whose symptoms are refractory to oral medication.

In measuring the effectiveness of a therapeutic test, consideration must be given to psychologic factors in evaluating a good response. Consultation with a physician, acceptance of treatment and administration of pills, capsules or injections of vitamins, have produced cures of many conditions other than those resulting from nutritional deficiency.

For purposes of completeness a brief review of the early signs and symptoms of certain specific vitamin deficiencies will now be considered.

Table 4.—*Symptoms and Signs Which May Be Suggestive of Early Deficiency States*[1]

(1) General
  (a) Loss of weight
  (b) Loss of strength
(2) Oral
  (a) Sores at angle of mouth (cheilosis)
  (b) Stomatitis
  (c) Glossitis—red tongue
  (d) Red swollen lingual papillae
  (e) Papillary atrophy of tongue
  (f) History of sore tongue or mouth
  (g) Sore and bleeding gums
  (h) Serious dental abnormalities
  (i) Vincent's angina
(3) Gastro—Intestinal Trace
  (a) Lack of appetite
  (b) Chronic diarrhea
  (c) Failure to eat adequate breakfast
(4) Nervous System
  (a) Aversion to normal play
  (b) Poor sleeping habits
  (c) Backwardness in school
  (d) Lassitude and chronic fatigue
  (e) Lack of mental application
  (f) Nervousness and irritability
  (g) Paresthesias
  (h) Loss of vibratory sensation
  (i) Increase or decrease of tendon reflexes
  (j) Hyperesthesias of skin
(5) Skeletal
  (a) Poor muscle tone
  (b) Bad posture
  (c) Square head, wrists enlarged, rib beading
  (d) Muscle and joint pains, muscle cramps
  (e) Muscle tenderness, extremities
(6) Poor development
  (a) Failure to gain steadily in weight
  (b) Late period of sitting, standing, and walking
  (c) Inability to sit
  (d) Pain on standing and sitting
(7) Skin
  (a) Lack of subcutaneous fat
  (b) Wrinkling of skin on light stroking
  (c) Rough skin (toad skin)
  (d) Nasal blackheads and whiteheads
  (e) Nasolabial sebaceous plugs
  (f) Bilateral symmetrical dermatitis
  (g) Purpura
  (h) Dermatitis, facial butterfly, Casal's necklace, perianal, scrotal vulval
(8) Respiratory
  (a) Repeated respiratory infections
(9) Blood
  (a) Pallor
  (b) Hemorrhage of newborn
  (c) Tendency to bleed
(10) Cardiovascular
  (a) Rapid heart
  (b) Edema
(11) Eyes
  (a) Night blindness
  (b) Photophobia
  (c) Burning and itching of eyes
  (d) Lacrimation

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[1] Modified from a report of a subcommittee of the Subcommittee on Medical Nutrition of the National Research Council. T. T. Mackie, M.D., Chairman, May, 1941.

EARLY SIGNS AND SYMPTOMS OF SPECIFIC VITAMIN DEFICIENCIES—DEFICIENCY OF VITAMIN A

Clinical.—The most readily-appreciated symptoms of Vitamin A deficiency have to do with changes in the eyes. In conditions of mild deficiency, these symptoms consist principally of night blindness or inability to see clearly in dusky light, and of conjunctival irritation or lesions. A history of photophobia, blepharitis or dryness of the eyes may be indicative of the condition, and on gross inspection of the eyes there may be no changes or slight pigmentation, unusual dryness or a granular appearance of the conjunctivae. Abnormal dryness or scaling of the skin may be an early manifestation of Vitamin A deficiency and, subsequently, in more marked degrees of deficiency there develops a red papular eruption resembling goose flesh, or a horny type of eruption involving the skin principally of the extensor surfaces of the arms and thighs.

Laboratory or Objective Diagnostic Procedures.—For patients in whom one suspects the possibility of Vitamin A deficiency the following objective methods are available to aid in establishing the diagnosis: (1) determination of the Vitamin A or carotene content of the blood plasma; (2) measurement of alterations in dark adaptation by the biophotometer method, and (3) response of the patient to treatment with Vitamin A.

No one of these methods is entirely satisfactory from the standpoint of the general practitioner, because the use of the biophotometer is limited to practitioners in a large city and the diagnostic value of it is still in dispute. Estimations of the Vitamin A and carotene content of the blood plasma are procedures limited to experimental laboratories, and the value of such calculations as a means of establishing a deficiency of Vitamin A has not yet been clearly established.

Therapeutic Test.—A therapeutic test of 25,000 to 75,000 USP units of Vitamin A daily for a week or two should produce a prompt decrease in the early symptoms and signs of Vitamin A deficiency. Definitely established skin lesions may require more prolonged therapy.

Such a therapeutic test constitutes the simplest objective procedure in making the clinical diagnosis of Vitamin A deficiency; and while a positive result does not prove the diagnosis, none the less it is highly indicative of it.

DEFICIENCY OF THIAMIN

Clinical.—The early symptoms of thiamin deficiency have relation to the nervous system, and particularly to the nervous and psychic response of the patient. Indeed, the early symptoms have much in common with those of neurasthenia or psychasthenia, and include irritability, depression, weakness, quarrelsomeness, sore muscles, lack of coöperation, fear, anxiety, insomnia, and loss of weight. Subsequently the more common symptoms of peripheral neuritis including pain, paresthesias and weakness develop in the extremities. Anorexia is commonly present.

Laboratory and Objective Procedures.—Methods available include (1) determination of the thiamin content of the previous diet of the patient and comparison of it with the normal values; (2) determination of the thiamin values of the blood and urine; (3) determination of the pyruric and lactic acid values of the blood; (4) excretions of thiamin in the urine after a test dose of it, and (5) a therapeutic test. Recent studies by Williams, Wilder and associates indicate that the earliest stages of thiamin deficiency may be demonstrated by the determination of excretion of thiamine hydrochloride after administration of a test dose of it. In general these procedures, with the exception of a therapeutic test, are restricted to laboratories or clinics in which such studies and determinations can be made.

Therapeutic Test.—For the average physician the diagnosis of thiamin deficiency still depends on clinical phenomena and relief of them, following a therapeutic test with substances containing the vitamin. Administration of thiamine hydrochloride in 10 mg. doses several times daily, orally or parenterally, should, in the course of a few days to two weeks, result in prompt improvement or disappearance of nervous symptoms presumably due to thiamin deficiency.

Since deficiencies of the components of the Vitamin B complex almost always coëxist, the most satisfactory therapeutic test for them consists of administration of brewers' yeast in doses of 30 to 50 gm. daily, for one to two weeks, or of a concentrate of the complex in comparable doses parenterally if the gastrointestinal tract is not functioning normally.

DEFICIENCY OF RIBOFLAVIN

Clinical.—It is early stages ariboflavinosis may be manifested by (1) ocular symptoms consisting of photophobia, burning of the eyes, lacrimation and slight injection of the margins of the cornea; (2) oral lesions with linear fissures, redness and soreness of the corners of the mouth, and slight flattening of the papillæ of the skin, and (3) dermal lesions with seborrhoeis accumulations in the nasolobial folds and around the eyelids or ears.

Laboratory and Objective Procedures.—Such procedures are of questionable value. Determinations of the riboflavin content of the blood or urine can be made, but are restricted to specialized laboratories, and the interpretations of the results of them are still in the experimental stages. Examination of the cornea with the slit lamp, and discovery of loops or capillaries invading the cornea from the periphery, are considered by some investigators a useful means of detecting riboflavin deficiency in its early stages. If this abnormal vascularity disappears rapidly after treatment with riboflavin, the test is considered diagnostic. However, the diagnostic usefulness of the slit-lamp examinations is not universally accepted.

Therapeutic Test.—A therapeutic test with riboflavin, in doses of 5 to 10 mg. administered several times daily for a period of one to two weeks, with rapid clearing of the above noted symptoms, would constitute reasonably good evidence of previous riboflavin deficiency. As in the case of thiamin deficiency, a more satisfactory therapeutic test in ordinary conditions of practice consists of the administration of brewers' yeast as previously noted.

DEFICIENCY OF NIACIN

Clinical.—The early symptoms of pellagra, which is in large part due to deficiency of niacin and the components of Vitamin B complex, may be largely nervous in type and consist of restlessness, nervousness, insomnia, lassitude, irritability, easy fatigue, vague aches and pains, lack of energy, a tendency to excessive worry and similar symptoms frequently observed in patients with nervous exhaustion and other functional disorders of the nervous system. Associated with this there may be slight anorexia, glossitis with burning, redness and edema of the tongue, possibly slight diarrhea, and a mild dermatitis, suggesting sunburn and affecting principally the exposed surfaces of the backs of the hands, wrists, forearms, and face, usually in symmetrical fashion.

Laboratory and Diagnostic Procedures.—Unfortunately to date there has not been developed a satisfactory laboratory method for detecting niacin deficiency.

Therapeutic Test.—Administration of niacin and niacin amide in doses of 10 mg. six or eight times daily, for one to two weeks, or of powdered brewers' yeast in doses of 20 to 30 gm. three times daily for a similar period, should cause rapid regression and almost if not complete disappearance of the symptoms of niacin deficiency.

DEFICIENCIES OF PYRIDOXIN (VITAMIN B_6) PANTOTHENIC ACID, CHOLINE, BIOTIN, INOSITOL AND PARA-AMINOBENZOIC ACID

No specific symptoms in man have been established as characteristic of deficiency of these substances.

DEFICIENCY OF ASCORBIC ACID (VITAMIN C)

Clinical.—The most readily appreciable symptoms of ascorbic acid deficiency have to do with hemorrhagic phenomena, particularly small hemorrhages into subcutaneous, subperiosteal, gingival and other tissues. Delay in healing of wounds, sponginess and slight swelling of the gums, anemia, and fleeting pains in the extremities have been ascribed to slight deficiency of this vitamin, and are said to be characteristic of early deficiency of it.

Laboratory and Objective Procedures.—Methods available include (1) analysis of the Vitamin C content of blood and urine; (2) excretion tests of the vitamin following administration of test doses; (3) roentgenologic studies of bones, revealing changes in the ends of the bones characteristic of scurvy, and at times subperiosteal hemorrhage, and perhaps (4) capillary fragility and resistance tests. The normal range for Vitamin C in the blood plasma in adults is from 0.7 to 1.3 mg. per 100 c.c. Values above 1.0 mg. per 100 c.c. if confirmed probably would eliminate the possibility of ascorbic acid deficiency, while values below this level and, in fact, below 0.7 mg. per 100 c.c., would not necessarily confirm the diagnosis of a deficiency. Excretion tests, or administration of test doses and studies of elimination of them, have value principally for those interested in research.

Therapeutic Test.—Administration of orange juice in large amounts, or of Vitamin C in test doses of 200 to 1000 mg. daily in divided doses, should produce rapid disappearance of symptoms if they are due to deficiency of the vitamin.

DEFICIENCY OF VITAMIN K

Clinical.—Hemorrhagic phenomena in patients with hepatic disease, jaundice, striking gastrointestinal abnormalities, and in newborn infants, suggest the likelihood of Vitamin K deficiency.

Laboratory and Objective Procedures.—Numerous laboratory and bedside methods for determination of the so-called "prothrombin time" have been developed and are extremely useful in detecting deficiency of Vitamin K before it manifests itself clinically by hemorrhage, and in establishing the diagnosis, once bleeding has occurred.

Therapeutic Test.—Administration of one of the numerous preparations of Vitamin K, such as menadione, in doses of 1 to 2 mg. parenterally or orally twice daily for several doses generally, is a very effective therapeutic measure, as well as a test of deficiency of the vitamin.

DISCUSSION AND SUMMARY

To the average physician the most puzzling aspects of this problem are the lack of specificity of signs and symptoms of early nutritional failure, and the lack of simple specific objective tests to establish a diagnosis. Furthermore, there is difficulty in the proper evaluation of the relationship or lack of it between previous diet, symptoms or signs of early nutritional deficiency, and studies of the chemical values for vitamins in the blood and urine. It seems clearly established that there is not any correlation between these three factors.

Vague and nonspecific symptoms, such as fatigue, lack of energy, inefficiency, irritability, nervousness, anorexia, slight weight loss, insomnia, restlessness, and vague aches are common in early nutritional failure; but they occur also in a host of other functional and organic diseases.

For the practical purposes of the average practitioner of medicine the most satisfactory methods of settling the possibility that symptoms are the result of nutritional deficiency, are, first, to rule out other causes for them by a carefully-evaluated history and examination; second, by study of the previous diet of the patient, and, finally, by administration of an adequate diet, meeting the recommended daily allowances established by the Food and Nutrition Board of the National Research Council, with or without supplements of vitamins in concentrates and synthetic form, over a period of two to four weeks.

In only occasional cases will it be necessary to continue specific therapy over a longer period of time to establish evidence of a previous dietary deficiency, and only rarely will it be necessary to resort to parenteral administration of the vitamins as a test measure.

Disappearance of symptoms, following such a therapeutic test, is a happy outcome. It indicates, but does not establish or prove a previous dietary deficiency. The results must be tempered with clinical judgment of psychogenic factors which may play a significant rôle in alleviating nonspecific and general symptoms.

To sum up, physicians must still use their clinical judgment in recognizing the early stages of vitamin deficiency, and, in making a diagnosis, must depend chiefly on an evaluation of the vitamin content of the previous diet of the patient, on the presence of signs and symptoms suggestive of deficiency disease, and on disappearance of these findings following use of an adequate diet and administration, for a limited period of time, of therapeutic doses of the vitamins.

237 Fourteenth Avenue.

THE PRACTICAL USE OF VITAMINS IN WARTIME*

Howard F. West, M.D.

Los Angeles

THOUGHTLESSLY, the busy practitioner may commit either one of two errors: (1) totally ignore the importance of vitamins in nutrition, or (2) indiscriminately advise or condone the use of unnecessary commercial preparations. Either fault would dodge one of our real responsibilities; for we, as physicians, have the great responsibility of putting our patients and their families straight on this whole vital problem of nutrition. They look to us to be the final referee in all matters of health. No longer can we pass off this subject of nutrition with a shrug, nor fall back on the old admonition, "Let your appetite be your guide."

They must be told:

That adequate nutrition is the primary basis for optimal growth, development, and general good health.

That vitamins are real, tangible, essential chemical substances—not mysterious ghosts, nor merely subjects for a good joke.

That they are required as catalysts or accelerators to make available our building and energy foods, proteins, carbohydrates and fats, for the creation and maintenance of normal tissue structure and function.

That Nature has provided them as components of our normal natural foods.

That they are not all present in all foods; therefore, the need for a properly selected, "balanced" diet.

That they may be lost, all or in part by over-refinement, by improper cooking, heating and preserving.

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Department of Clinical Medicine, University of Southern California School of Medicine.

That vitamins, by themselves, are not foods, and that by no stretch of the imagination can they replace proteins, carbohydrates, fats, adequate calories nor minerals.

That no vitamins will relieve fatigue, restore "pep," nor prevent infection when these conditions are due to causes other than vitamin deficiency.

PRESCRIPTION OF VITAMINS

The prescription of vitamins, as such, is usually considered from two points of view: (1) that of their curative properties, when actual signs and symptoms of deficiency already exist, and (2) that of their protective value, when there is reason to suspect that the diet is inadequate and can not be corrected.

Today, more than ever, should each patient have a nutritional survey as part of any medical examination. This should include a search for physical or functional evidence of vitamin and other deficiencies—(see article by Dr. Wilbur in this series). Should such evidence be demonstrated, then appropriate concentrates of specific vitamins should be given in adequate dosage to effect a cure. It is important to remember that, in the treatment of vitamin deficiency disease, best results are obtained when full reliance is not placed on synthetics or concentrates alone, but when these are combined with a fully adequate vitamin-rich diet of carefully selected and prepared food. It is also important to remember that, in general, single deficiencies seldom occur. One may be dominant, but if the background is such as to encourage one deficiency, others are apt to be present in greater or less degree.

Evidence of deficiency, clinical or "subclinical," may be present because the subject has habitually followed an inadequate diet due to ignorance, careless choice, faddism, poverty, prescribed "diets" or perhaps because he has been more or less entirely dependent upon restaurant food. In these busy days, people tell us that they do not have time to market and to prepare food properly, or that eating facilities at or near their place of employment are entirely inadequate. Perhaps patients have not learned to adjust their eating habits properly to the restrictions of rationing.

Aside from the special wartime problems of today, the physician must continue to be alert to the effects of chronic disease on the nutritional status of his patients. The "clinical picture" of chronic, prolonged, gastro-intestinal disease, chronic heart failure, long-continued infections, as well as chronic alcoholism and mental disorders, may be due in considerable part to various nutritional deficiencies. Certainly for these patients, supplementary vitamins are indicated. They should be selected to relieve the deficiency which is present, and should be given in adequate dosage.

Before advising the use of vitamin supplements by the worker and others able to ingest and digest adequate quantities of food, one should always make every effort to determine dietary habits and, if indicated, make emphatic the need for a proper food program. If the patient is not regularly consuming adequate quantities of each of the "Basic Seven Foods," it is hardly probable that he is following a fully adequate food program. Not only are the chances good that his vitamin intake is below standard, but that other essential elements are also lacking or present in insufficient quantity.

STANDARDS OF THE FOOD AND NUTRITION BOARD OF NATIONAL RESEARCH COUNCIL

When attempts are made to meet the minimum standards recommended by the Food and Nutrition Board of the National Research Council, it is apparent that most difficulty is encountered in regard to fully-adequate amounts of the B complex and especially thiamin. In general, in California, because of the availability of citrus fruits and green vegetables, it is relatively easy to suggest a food program containing generous amounts of Vitamins A and C: 3½ oz. of green vegetable, or 3½ oz. of carrots, or 4 oz. liver, or 3½ oz. Hubbard squash will each provide over 6000 units of Vitamin A or its precursor carotene. One-half grapefruit, or one orange will supply over 75 mg. ascorbic acid (C), in addition to that derived from other fruits and vegetables such as cabbage, tomato and musk melon. In spite of generous amounts of sunshine on this coast, most infants and young growing children, as well as pregnant women, should have supplementary vitamin D, as available in fish-liver oils or their concentrates. Thought should also be given those persons who work night shifts or are otherwise kept too much out of the sun. It is probably wise to protect these people with approximately 400 international units of a potent supplement per day.

To return to the B complex: numerous surveys by competent investigators have demonstrated that, as a people, we are most likely to be deficient in this group. The increased use of refined carbohydrate food, such as highly-milled white flour and sugar has encouraged a general deficiency in two ways; (1) by lowering the intake of B from natural sources and (2) by increasing the requirements. It is to be remembered that the higher the carbohydrate content of the diet and the higher the total caloric intake, the greater are the requirements for the B group vitamins. This is especially true in relation to thiamin (B_1). As emphasized by Mrs. Hardgrove, the diet must be carefully selected and carefully prepared, so as to avoid losses through storing and cooking in order to meet the minimum standards for daily thiamin (and other components of the B group) intake.

The normal requirement of thiamin appears to be proportioned to the total metabolism or total food intake, rather than to the body weight. Thus the child requires more in proportion to its size than the adult. Vigorous physical activity or over-feeding increases the thiamin requirement. It is also affected by the relationship between fat and nonfat calories in the diet, increase in the proportion of fat decreasing the need for Vitamin B_1. In hot weather there should be an extra provision for this vitamin in the diet. The greater the gastro-intestinal wastage, the greater must be the thiamin intake. Infections, fevers, and other processes which stimulate oxidation correspondingly increase the vitamin requirement.

The literature of the past few years has been inclined to stress particularly the wide-spread inadequacy of thiamin in the average diet. Consequently, there has perhaps been too great a tendency to advise the use of this separate entity (usually synthetic)to the neglect of other members of the complex. Also it must not be forgotten that there is evidence that there are components of the B complex that so far have not been positively identified. There is evidence, too, that when the whole complex is taken in quanitatively normal or natural proportions, better results can be expected. Consequently, when the daily diet can not be made adequate or, for therapeutic reasons, it seems advisable to prescribe supplements, it is best and cheapest to use a natural source, such as brewers' yeast, wheat germ or rice polishings, when this can be done. One ounce of a good strain of brewers' yeast will provide approximately 1.6 milligrams Thiamin, 1.1 milligrams Riboflavin and 11.4 milligrams Niacin and, in addition, other valuable components of the B group.

It has been pretty definitely proven that increasing the intake of vitamins above quantities normally needed will not increase efficiency, endurance, nor strength. If physical inefficiency is due to vitamin lack, then supplementary sources of these substances will improve the situation.

IN CONCLUSION

The above paragraphs have been written with the belief that the private physician should concern himself with the nutritional status of each patient, and thereby indirectly with that of the family. There can be no disagreement with the point of view that good nutrition is the basis for good health, and that food, properly selected and prepared, is far superior to pills and capsules. On the other hand, he must be alert to evidences of vitamin deficiency, and if found, treat them adequately.

There is another aspect of the problem that concerns those who are dealing with large groups of individuals under wartime pressure, such as thousands currently engaged in the war industries. Impatient with the slow processes and effectiveness of education, and the delays and handicaps encountered in establishing adequate feeding facilities in industry, many of these workers feel that time will be saved, efficiency increased and absenteeism reduced, if each worker is supplied daily with vitamin supplements. So long as such a measure is recognized purely as a stop-gap procedure, and the worker is not persuaded by example that this will solve his nutritional problems, this point of view is possibly justified.

1930 Wilshire Boulevard.

A COÖPERATIVE ENDEAVOR TOWARD NUTRITION IN INDUSTRY*

W. Palmer Lucas, M.D.

San Francisco

Nutrition in Industry is not just a simple problem of nutrition, as it is generally understood. It is more complex because it takes in more than the nutrition and malnutrition of individuals, and the adequate feeding of these individuals with the proper constituents of a balanced diet. It includes in addition:

1. The question of getting food to aggregations of workers.

2. The complications arising because of the various federal agencies with different points of view . . . e.g. The Manpower Commission requires a maximal number of workers healthy and on the job a maximal number of hours; the Maritime Commission has the production goal to accomplish, and thus approaches the question from that standpoint; while the Food Distribution Administration, Nutrition in Industry Division takes as its goal adequate in-plant feeding, with proper facilities and accommodations to do the job.

3. The Concessionaire approaches the problem from the standpoint of availability of food, the allotment of ration points, and the adequacy of facilities and manpower to carry out the feeding project.

Faced with this complex problem, the first necessary move of the Bay Area Nutrition in Industry was that of acquiring funds for a coöperative and coördinated organization for the industries in the Bay Area. Realizing that tuberculosis and nutrition were closely-related problems, the Tuberculosis Associations of San Francisco, Alameda, San Mateo, Marin, and Contra Costa Counties agreed to finance the project for the present year. Representatives from these associations and from the five county Nutrition Councils, constitute the Executive Committee. The actual Working Committee of this organization, which meets weekly to formulate new plans and discuss latest developments, is comprised of Herbert C. Moffitt, M.D., Chairman; W. Palmer Lucas, M.D., Acting Chairman; Wm. C. Voorsanger, M.D., Secretary San Francisco Tuberculosis Association; Harold T. Castberg, M.D., Chief, Bureau of Industrial Hygiene of the State Board of Health; Miss Jane Sedgwick, Nutritionist, State Board of Health; Mr. William Broeg, Industrial Nutritionist, FDA; Merrill Kelly Bennett, Ph.D. of the Stanford Food Research Institute; with the two full-time paid nutritionists, Mrs. Filsinger, and her assistant, Mrs. Hanson.

NUTRITIONAL NEEDS OF WORKERS

Although the health and welfare of the worker is a definite contractural requirement of the managers of industry, the nutritional needs of the worker have not been sufficiently emphasized. At the Lockheed Aircraft Plant in Burbank, California, a nutritional study was made under the general direction of the Nutrition in Industry Division of the National Research Council. Dietary histories of the workers were collected by Dorothy Wiehl and reported in the October, 1942, *Millbank Quarterly*.

In this study, it was found that only 2 per cent of the diets included amounts recommended as the dietary pattern by the National Research Council, Committee of Food and Nutrition, for five essential food groups; 11 per cent had "marginal" diets or moderately below standard, while 87 per cent had diets which were unsatisfactory for one or more food-groups.

Similar studies were carried on by the Nutrition in Industry Committee of ths Alameda County Nutrition Council. A breakfast survey disclosed that 63.9 per cent of the breakfasts of workers in a San Francisco Bay Area war industry were poor or omitted entirely; 21.9 per cent were "marginal" or moderately below standard, and 14.2 per cent were inadequate. A survey of home-packed lunches carried to one of the major shipyards in the San Francisco Bay Area disclosed that 40 per cent of the lunches were adequate for heavy work; 25 per cent were adequate for light work; and 35 per cent were inadequate for either light or heavy labor.

The Bay Area Nutrition in Industry Committee has now functioned for over 14 months, and the major problems it has faced have been:

1. Acquiring the coöperation of the managers of industry in the realization of the nutrition problems of their workers and action in accomplishing the Committee's goal toward adequate in-plant feeding. This has been an up-hill pull, not because management does not believe in nutrition and adequate feeding facilities, but because their major goal is production.

2. The difficulty that management envisions in getting adequate food to the men at their places of work is often more imagined than real. Every situation that we have studied has had possibilities for successful in-plant feeding.

3. So far the most insurmountable problem has been the Maritime Commission, which furnishes most of the funds for extra facilities in the yards contracted by the Commission. The attitude of its members in this area has been that they are opposed to in-plant feeding. As a compromise for this, they are most interested in the lunch boxes brought from home, and are, at present, constructing markets where workers can buy food for home and lunch consumption. As has been indicated, box-lunches are satisfactory neither from the standpoint of the one who eats them, nor that of the concessionaire who sells what is put up.

The second (educational) objective of the Bay Area Nutrition in Industry Committee has been accomplished as follows:

1. *Walt Disney Posters.* A series of three Disney posters are entitled, "You Can't Breakfast Like a Bird and Work Like a Horse," "A Goofy Lunch Pulls Your Punch," and "There's Fightamins in Fruits and Vegetables." These posters are enlivened by Disney's famous

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Offices of the San Francisco Nutrition Council and Nutrition in Industry for the Bay Area.

movie characters who carry this vital message to the people of the United States. They were made possible by the financial coöperation of this Committee and the Nutrition in Industry Committee of Los Angeles.

2. *Nutrition Classes.* An attempt has been made to provide classes in all the housing projects adjacent to the shipyards. Meeting with the workers for informal discussion of their problems has been found far more effective than formal lecture-classes.

3. *"Kitchen Door Kanteen."* A food and nutrition column edited by this Committee is offered to any shipyard and industrial publication. We are now serving six such publications, and attempt to meet all requests which come to us from editors of shipyard publications, and from the workers in the Women's Council Meetings we attend. We attempt to personalize these columns to the various conditions of each yard, and thus to do away with stereoptyped material so frequently left unread. This column gives weekly menus worked out under the ration system for families of two, four, or even one person living alone, to say nothing of the groups of bachelors trying to get enough to eat on their point allotments per week; it includes extenders for meat and butter as well, Thanksgiving suggestions for 1943, and many lunch box suggestions, with innumerable other themes fitting to the moment and the problems.

4. *"Recipes and Suggestions for Wartime Feeding."*[*] Industrial cafeteria managers have been supplied with this folder, in order to receive solutions for their feeding problems under the present rationing system. There has been a great demand for these booklets from other sources, also having wartime feeding problems to meet. Three hundred copies sent to San Mateo County have helped the restaurateurs to keep their establishments open at a time when a large number were planning to shut down.

5. *Wartime Feeding Centers:* as the markets have been developed at the various yards, the Bay Area Nutrition in Industry has proposed the development of Wartime Feeding Centers staffed with Red Cross Nutrition Aides trained in their counties to answer questions on rationing, food preparation, meal planning, and also to distribute recipes and general nutrition material. Our first such center is located in the heart of the Government Housing Project in Richmond, California, in close proximity to the great Kaiser Shipyards. This project was taken over by the Richmond Red Cross Nutrition Committee, under the leadership of Mrs. Mildred Barrows. Here throngs of industrial workers shop at a spot where the Nutrition Aides may bring nutrition information to housewives and industrial workers, at the time and place where they need it most.

6. *"California Victory Lunch Boxes."* This newest project is a threefold leaflet decorated in the national colors, carrying as a front design the map of California in the background with an industrial worker in the foreground. This leaflet carries lunch box suggestions and pointers helpful to any person packing a lunch, whether he be an industrial worker or a school child.

7. *Posters.* This committee has designed original posters to meet the requests and demands of industry.

Thus it is that, through the combined accomplishments of the Bay Area Nutrition in Industry and the local, State, and Federal agencies, this committee stands hopeful that, in the not too distant future, the industrial feeding program in this area will be met, and that hot, nutritious food will be served to every contributor to the second line of defense on the home-front.[†]

2245 Post Street.

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[*] The O.P.A. has requested permission to print 55,000 of these for distribution throughout the five Pacific Region States.

[†] After 14 months of effective pioneering work, the Bay Area Nutrition in Industry Committee has dissolved. Partially financed by the San Francisco Tuberculosis Association, the committee engaged in a well-rounded program to solve and simplify many nutrition problems which the war brought to industry in California.

Mrs. Filsinger, who was lent to the B.A.N.I. Committee to serve as chief nutritionist and Executive Secretary, has now resumed her former position as Home Economist for the Pacific Gas and Electric Company. In the future she will be available, as a representative of the company, to contribute a similar service to industrial and commercial companies who do in-plant or employee feeding in the city and county of San Francisco.

Mrs. Filsinger has been appointed chairman of the committee on industrial nutrition by the San Francisco Nutrition Council, and has pledged support of the council for the continuance of the program.

THE SCHOOL LUNCH PROGRAM[*]

Ann Peril Purdy, M.D.
San Francisco

The importance of providing school lunches of good nutritive value is well recognized. Better health, development, attendance and scholarship have resulted from adequate feeding. Feeding needy school children, originally by private charity and later at public expense, has been an old European practice. The famous Oslo Breakfast consisted of black bread, a hunk of goat's cheese, a raw carrot, a glass of milk, and an apple. The rate of growth of children on this diet increased 118-140 per cent. This almost perfect ration required neither equipment nor service. Such phenomenal results suggest that good food can build almost anything.

Cheap or free school lunches have long been served in the United States as a convenience. Until the Depression, the feeding of undernourished children remained a private charity. The Depression presented us with an enormous biological problem, the protection of children, and through them the generations to come. An attempt was made to make the economic problems of the depressed 1930's solve each other—unemployment, the glut of agricultural products, and the undernourishment of children.

Some 65,000 unemployed people prepared and served to two million school children the surplus farm commodities. These were distributed to millions of underprivileged families, and to schools through the welfare agencies. Thus, through the Depression large numbers of underfed children received one good meal daily.

Though the motive was to avoid food waste and price depression, benefit accrued to the farmers, to the unemployed and to six million children. The plan met with apathy and opposition. We were willing to spend $100 a year on a child's education, but loath to add $15 more to insure his ability to learn, though teachers agree that adequately-fed children show better development and adjustment, make greater intellectual progress without conscious effort, and have fewer illnesses—a decrease in the cost of education. The physician knows, furthermore that (1) normal development requires adequate nutrition, (2) optimum nutrition produces maximum development, and (3) deficiencies during critical growth years may do irreparable damage to the individual and, through him, to the race.

Germany's policy of "selective starvation" of the next generation of nonGerman, European children, and mass deportation "birth control" guarantees a biological German victory, and Germany anticipates overrunning Europe with her superior children. It behooves us to give attention to what Hoelzel calls the "nutritional determination of history."

We are turning from diet standards sufficient to sustain life to optimum standards that mobilize full capacities. Such a dietary ideal for every child is consistent with a democratic society, but we fall short of providing every child with even a minimal diet, and, despite our high-living standards, one-third of our people lack protective foods to the level of mild deficiencies. Were the yardstick of optimum nutrition applied, few would qualify.

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[*] One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

The far-reaching school lunch attacks the problem directly and can become a great vehicle for mass nutrition education. It feeds, while training the child and his parents.

The program grew rapidly, but it is still too young to survive unaided. As school lunches were given preference in the defense program, so the overall wartime food administrators still feel that school lunches are of long range strategic national importance.

THE SCHOOL LUNCH

The Government has contributed $5,000,000. Local groups must provide equipment, labor, supervision, and 40 per cent of the locally bought food.

The school lunch should:

1. Be served under good conditions.
2. Contain *enough* of the right foods.
3. Contain much of the day's essential nutrients.
4. Be adjusted to the nutritional, racial and religious needs of the child and complement the home diet.
5. Be a plate lunch, which improves quality, lessens cost, reduces labor, saves food, provides variety, broadens tastes and food balance.
6. Develop good eating habits.
7. Be a part of health education.

Nutrition is a vital part of health education, and the school lunch should bridge the gap between theory and practice. Good food habits are not instinctive in man, but are wholly a matter of education. Man welcomes science in animal feeding, but resents it at his own table.

Some people see in this program undesirable social trends, but they fail to see the full significance of the degradation of our food which has taken place simultaneously with, and in part as a consequence of great scientific and industrial advances. They are sceptical of the seriousness of child malnutrition, because they do not realize that these advances have stripped our abundant and alluring foods of many of their vital qualities.

The physician must play a responsible rôle in the program because:

1. The science of nutrition promises a higher national health.
2. The doctor is the health consultant.
3. The physician must help set feeding standards.
4. The physician must weigh results.
5. The physician must select and certify children for special feeding.
6. The physician is held responsible for the health of the nation's children, and the quality of the generations to come.

The physician should, therefore, play a prominent rôle in the groups concerned with a community nutrition.

SUMMARY

The School Lunch Program has passed through the stages of private and public charity, and is now a public responsibility. The malnutrition of millions of children during the Depression emphasized the need of protecting a great national resource, shown by our newer knowledge of nutrition, to be in jeopardy.

Such feeding developed in the United States as an agricultural and unemployment relief policy, but has become a part of health education in the schools. It attacks malnutrition directly, while removing ignorance as an underlying cause.

Though the wartime food program has extended to all the people of the United Nations, and to the revamping of world agriculture, the problem of feeding American children continues to be of prime importance. Congress has appropriated $5,000,000, to insure to all children one good meal a day, despite poverty, ignorance and indifference, and despite food shortages, rationing and family dislocation.

722 Funston Avenue.

THE LITERATURE OF THE WARTIME NUTRITION MOVEMENT*

Ruth Okey, Ph.D.
Berkeley

SOME review of the origins of our war-time literature in nutrition is essential to an appreciation of its values and limitations. The first large impetus was given to a program for better nutrition in America with the President's call for a national nutrition conference in May of 1941. This conference adopted the "Recommended Daily Allowances" for basic nutrients [I (1)] of the National Research Council as a working "yardstick" for measuring the adequacy of American diets. It also planned a program designed to make possible for every American a diet which would measure up to this standard.

To carry out this plan State and county nutrition committees had already been organized and a nutrition service had become part of the Office of Defense Health and Welfare Services. The Red Cross, the AWVS and many other agencies started nutrition classes, and one large grocery chain prepared a very good nontechnical correspondence course in nutrition.

The new nutrition program got under way with the slogan, "Eat the Right Food to Keep Fit" (I, 3) and we heard much about "buoyant health" in contrast to mere lack of illness. Food was plentiful in the United States in 1941, and nutrition programs were formulated on the basis that we would be able to have anything we needed and almost anything we wanted. Pressure was brought to bear on newspapers, magazines, the radio and, above all, on advertising firms, food producers, manufacturers, and distributors to make the public nutrition conscious.

Some of the best advertising talent and a large proportion of the food advertising budget was devoted to "contributions to the national nutrition program." Many of these made an honest effort at scientific accuracy, and were really formulated with the motive of service uppermost. The trained copy-writers, the gorgeous color photography, and the elaborate and interesting lay-outs of this commercial material put sadly in contrast the stilted phraseology, and the poor and unattractive printing of most of the scientific publications. Unfortunately, rigid adherence to fact seldom makes a story which can compete with that which admits of exercise of the imagination. Effective advertising has to tell a good story.

As the war has produced food shortages, and the emphasis in the nutrition program has had to be shifted from best choices from an abundance of foods to best use of the foods we have or can produce with a minimum cost for labor, the accuracy of our nutrition information has become more important. It didn't seem to matter so tremendously, two years ago, that a meat chart should be based on a protein allowance 10 grams above the NRC standard allowances, while figures for other nutrients held to the standard, or that the pictured serving portions of meat were 20 grams larger than those of the other foods shown. Today, our point of view is altered. We can't afford the distortion of the picture which so many of our advertising agencies seem to feel their rightful "plug" for the product advertised.

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* One of several papers in a Symposium on "Civilian Wartime Problems in Nutrition: From the Standpoint of the Physician." Papers collected by Lt. Comdr. Dwight L. Wilbur, MC-V(S), U.S.N.R.

From the Department of Home Economics, University of California, Berkeley Campus.

Sorting the grain from the chaff has become an herculean task. The frank advertisements of food products which give tested recipes for their use and menus into which they fit, are probably our most valuable commercial circulars. Even these may need checking on the basis of retention of food values during preparation. It is definitely safer to confine one's recommendations to material known to have been checked by a reputable and noninterested agency, and it seems desirable to know what we can find in this category.

The following list is limited to some of the noncommercial publications which the writer believes may be most useful to the physician in California:

I. NATIONAL NUTRITION PROGRAM:

1. *Proceedings of the National Nutrition Conference of May, 9141.* Supt. of Documents, Washington, D.C. 35c.

2. *Food for a Stronger America.* Survey Graphic reprints. 1941. (Condensed report of the above.) 15c.

3. *Eat the Right Food to help keep you fit.* 1941 (see text) Supt. of Documents, Washington, D.C.

4. *Are We Well Fed?* Misc. Pub. U.S.D.A. #430. (Graphic condensation of the results of the dietary surveys by the Bureau of Labor Statistics and the Bureau of Home Economics. See text) Supt. of Documents, Washington, D.C. 15c.

5. *Hidden Hungers in a Land of Plenty,* National Maternal and Child Health Council. Obtainable from A.A.U.W. 1634 Eye Street N.W., Washington, D.C. 25c.

6. *This Problem of Food,* by Jennie Rowntree. Public Affairs. Committee, 30 Rockefeller Place, New York City.

7. *Planning for Total Food Needs* (of the country) by E. C. Vorhies, 1942. (One of a series of U. C. publications on Foods in Wartime. U. Calif. Press.) U. C. Press, Berkeley. 25c.

8. *Nutrition Reviews.* (Monthly periodical, each issue consists of 25 to 30 pages of brief and well-written reviews of new work in nutrition. Should be valuable to the physician.) Nutrition Foundation, Inc., Chrysler Building, New York, N. Y. $2.00 per yr.

9. *Inadequate Diets and Nutritional Deficiencies in the United States.* Bulletin of the National Research Council #109, November, 1943. Published by the National Research Council. Copies distributed by Mead, Johnson and Co., Evansville, Indiana.

II. WHAT CONSTITUTES A NORMAL DIET:

1. *Recommended Dietary Allowances,* National Research Council. Reprint and Circular Series #115. Jan. 1943 (see text) 2101 Constitution Avenue, Washington, D. C. (No charge)

2. *Planning Diets by the Yardstick of Good Nutrition:*
    (a) Low Cost (3 Market Orders)
    (b) Moderate Cost (1 Market Order)
    (c) Liberal Cost (1 Market Order)

Bureau of Human Nutrition and Home Economics. U.S. D.A. 1941. (Now available as separate sheets showing quantities of food required for one week. All were done before rationing. Supt. of Documents, Washington, D.C. $1.25 per hundred.

3. *Checking Food Values of the Daily Diet* by Hilda Faust, Home Demonstration Service. U. of Calif. 1943. (Nutritive values of foods in terms of common measures. Includes standards, and a form for recording and computing a day's food intake.) U. C. Press, Berkeley. 2½c per copy or $1.25 per 100.

III. ADJUSTMENTS TO RATIONING AND FOOD COSTS:

1. *Wartime Food for Four Income Levels,* by Ruth Okey and Edith J. Linford. Publication of the Heller Committee for Research in Social Economics, 1944. (Four sets of market orders for one week for families of four—adjusted to the income and needs of the executive, the white-collar worker, the skilled wage-earner doing manual work, and the family needing an adequate diet at minimum cost. All have been checked for nutritional adequacy. Menus are given for each and prices are included for San Francisco as of March, 1944. Ration adjustment to March, 1944. U. C. Press, Berkeley 35c.

2. See also material on individual foods—section V.

IV. THE MANAGEMENTS OF PATIENTS REQUIRING SPECIAL THERAPEUTIC DIETS:

Low Cost Special Diets. Parts II and III by a committee of the California State Dietetics Association, 1942 (Dietary plans, menus, and market order for most of the special diets likely to be required in the outpatient clinic. Made with low-cost foods likely to be available in wartime. Planned for use of doctors and dietitians only.) (Mimeographed copies on sale at ASUC store, U. C. campus, Berkeley).

V. PAMPHLETS DEALING WITH INDIVIDUAL FOODS AND THEIR USE IN THE WARTIME DIET:

1. *Series of leaflets.* U.S.D.A. Bureau of Human Nutrition and Home Economics, 1942 and 1943.
    a. Root Vegetables in Wartime Meals
    b. Green Vegetables in Low Cost Meals
    c. Dried Beans and Peas in Low Cost Meals
    d. Potatoes in Low Cost Meals
    e. Dried Fruits in Low Cost Meals
    f. Fats in Wartime Meals

(Discussion of the place of the food in the diet, special problems in its preparation, and recipes.) Each leaflet. Supt. of Documents, Washington, D.C. $1.00 per 100 copies.

2. *Soybeans for the Table.* Supt. of Documents, Washington, D. C. 5c each.

3. *Meat in Thrifty Meals.* U.S.D.A. Bulletin #1908, Supt. of Documents, Washington, D. C.

4. *Food Charts: Foods as Sources of the Dietary Essentials.* Prepared by a Joint Committee of the Council on Foods and Nutrition of the American Medical Association and the Nutrition Board of the National Research Council. Available as a 20 page pamphlet which reproduces charts and text showing contribution of nutrients by various foods. Distributed by Mead, Johnson and Co., Evansville, Indiana, without charge to physicians.

VI. CONSERVATION OF NUTRIENTS IN FOOD PREPARATION: VITAMINS:

1. *Saving Food Values II.* H. Faust and V. Greaves. Home Demonstration Service, U. Calif. (A review in outline form of the changes which occur in the nutrient values of foods during preparation, processing, and storage. Meant for the reader with some educational background.) U. C. Press, 3c each, $1.25 per hundred.

2. *Saving Food Values III.* H. Faust and V. Greaves, Home Demonstration Service, U. of C. (A simpler form of the above, illustrated and designed for use by the less well-trained housewife.) U. C. Press, 2c each, $1.00 per 100.

3. *Vitamin Values of Foods in Terms of Common Measure* (Tables of average only) prepared by U. S. Bur. Human Nutrition and Home Economics. Misc. Pub. #505, U.S.D.A., Supt. of Documents, Washington, D. C. 25c.

4. *Compilation of Detailed Results of Vitamin Assays of Food in Relation to Processing and Other Variants.* Booher, L. E., Hartzler, E. R. and Hewston, E. M. (Technical and not adapted to use by untrained persons.) U.S.D.A. Cir. #638. 244 pp. 1942. 25c.

VII. INDUSTRIAL NUTRITION:

1. *Food and Nutrition of Industrial Workers in Wartime.* National Research Council Circular Series 110. (First Report of Committee on State of Nutrition in Industry. Analysis of dietary deficiencies, practical considerations and recommendations.) Obtainable from National Research Council, 2101 Constitution Avenue, Washington, D. C.

2. *Planning Meals for Industrial Workers.* U.S.D.A. Food Distribution Administration Bulletin N.F.C.-2 June 1943. (Practical suggestion for feeding.)

VIII. CHILD NUTRITION AND THE SCHOOL LUNCH PROGRAM:

1. *The Road to Good Nutrition,* L. Roberts. Children's Bureau, U. S. Dept. Labor, Supt. of Documents, Washington, D. C. 15c.

2. *Food for Growth.* U.S.D.A. A.W.I.-1 (free).

3. *Building a Good Body.* 4 pp. by H. Faust, U. C. Press, Berkeley 2-49 copies 2c each, 100 or more 1c each.

4. *School Lunches.* 1940. Misc. Pub. #408 U.S.D.A. 10c.

5. *How to Feed Nursery School Children.* M. E. Sweeney and Dorothy C. Buck. Merrill-Palmer School.

6. *Well Nourished Children,* folder 14, Children's Bureau, U. S. Dept. Labor.

7. *Food for Children.* Farmer's Bulletin #1674. U.S.D.A. Supt. of Documents, Washington, D. C. 10c.

Department of Home Economics, U. of C., Berkeley.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

SPECIAL MEETING: C.M.A. HOUSE OF DELEGATES

Important. Attention of C.M.A. Members Is Called to Stiff Paper Red Ink Insert, Opposite Page 280 (Original Article Section).

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the One Hundred Eighty-fifth (185th) Meeting of the Executive Committee of the California Medical Association

An informal meeting of members of the C.M.A. Executive Committee resident in San Francisco, was held in San Francisco, on Monday, October 9, 1944, at 6:00 P.M.

By mail vote, the minutes which follow, and the actions taken, were approved by all members of the Executive Committee.

1. Roll Call:

Present: Drs. John W. Cline, Chairman; Philip K. Gilman, Council Chairman; Karl L. Schaupp, Past-President; and George H. Kress, Secretary-Treasurer.

Present by Invitation: Councilor Lloyd E. Kindall of Oakland.

2. Proposed Alameda County Letter Regarding C.P.S.:

The purpose of the informal conference was to consider a letter of October 3, 1944, addressed to the Committee by Councilor Kindall, the same relating to an enclosure that was a preliminary and confidential draft of a letter concerning California Physicians' Service, in preparation by a limited number of members of the Alameda County Medical Association, the said letter to be mailed to all members of the California Medical Association.

Councilor Kindall stated that when the proposed letter came to his attention, he felt it was his obligation as a Councilor of the California Medical Association to call the same to the attention of the C.M.A. Executive Committee.

The nature of the letter and its possible effect concerning capacity of service by California Physicians' Service, were then considered in informal discussions.

Councilor Kindall stated he did not know how many signatures would be attached thereto, but he was under the impression there would be ten or more names.

The question was asked whether it would not be possible to have the group who were proposing to send out the letter appoint a sub-group that could meet with the San Francisco members of the C.M.A. Executive Committee to talk over the issues involved in an informal, round-table dinner conference, in hope of clearing up some of the issues upon which criticism was made. . . .

3. Woman's Auxiliary Publication, "The Courier":

Secretary Kress presented a letter dated September 23, 1944, received from Mrs. Ralph Eusden, President of the C.M.A. Woman's Auxiliary. Request was made therein that the C.M.A. match the budget of the Woman's Auxiliary to make possible a larger edition of the Auxiliary publication, *"The Courier."*

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† For complete roster of officers, see advertising pages 2, 4, and 6.

This request was made because lack of space in CALIFORNIA AND WESTERN MEDICINE had made it impossible to continue publication of a Woman's Auxiliary department in CALIFORNIA AND WESTERN MEDICINE.

Secretary Kress stated that Executive Secretary Hunton calculated the cost of a page in CALIFORNIA AND WESTERN MEDICINE to be about $30.00 and that the Woman's Auxiliary had averaged one or two pages per issue in CALIFORNIA AND WESTERN MEDICINE, or $360.00 to $720.00 per year.

The request of Mrs. Eusden was that the C.M.A. match from C.M.A. funds, the Woman's Auxiliary budget of $375.00 for the publication of "The Courier," to permit a larger and more frequent publication. The San Francisco members of the Executive Committee felt this would be a proper procedure because the Woman's Auxiliary is no longer receiving space in CALIFORNIA AND WESTERN MEDICINE, and it was agreed that this recommendation should be made to the other members of the C.M.A. Executive Committee.

JOHN W. CLINE, M.D., *Chairman,*
GEORGE H. KRESS, M.D., *Secretary.*

Minutes of the One Hundred Eighty-sixth (186th) Meeting of the Executive Committee of the California Medical Association

An informal meeting of members of the C.M.A. Executive Committee resident in San Francisco, was held in San Francisco on Thursday, November 2, 1944, at 12:00 o'clock noon. These minutes were approved by mail vote.

1. **Roll Call:**

Present: Drs. John W. Cline, Chairman; Philip K. Gilman, Council Chairman; Karl L. Schaupp, Past-President; and George H. Kress, Secretary-Treasurer.

Present by Invitation: Dr. T. Henshaw Kelly; Mr. John Hunton; Hartley F. Peart, Esq. and Howard Hassard, Esq.

2. **Letter which 21 members of the Alameda County Medical Society submitted for publication in "California and Western Medicine" containing statement in which they said they intended to send to all members of the California Medical Association.***

A letter dated October 17, 1944, sent to the Editor of CALIFORNIA AND WESTERN MEDICINE, by Dr. Sidney N. Parkinson of Oakland, with enclosure of a statement containing criticisms of California Physicians' Service by some 21 members of the Alameda County Medical Society was considered.

The statement referred to above had been previously submitted to members of the Council of the California Medical Association under date of October 23, 1944, by Council Chairman Gilman, whose attention had been called thereto by Councilor Lloyd Kindall. Chairman Gilman requested Councilors to submit suggestions in regard to future steps in procedure.

The Alameda statement was discussed from different angles. The San Francisco members of the Executive Committee agreed to recommend to the full membership of the Executive Committee as follows:

1. That the statement submitted by Dr. Parkinson on behalf of 21 members of the Alameda County Medical Society concerning C.P.S. be printed in the December issue of CALIFORNIA AND WESTERN MEDICINE, it being too late for appearance in the November issue because that number was in press.

2. That the Council at its meeting on December 3rd consider formulation of a draft in reply to the criticisms made by the 21 members of the Alameda County Medical Society, for possible appearance in CALIFORNIA AND WESTERN MEDICINE.

3. It was also voted that a special committee consisting of Legal Counselors Peart and Hassard, Executive Secretary Hunton and Secretary-Editor Kress be instructed to prepare drafts of replies, the same to be submitted to the Chairman of the C.M.A. Executive Committee for possible transmittal to members of the C.M.A. Council, for further suggestions as to content, form, etc.

4. Also, this committee to be instructed to draft replies to any new communications or procedures that might arise prior to the meeting of the C.M.A. Council of December 3rd, and to submit same to the Chairman of the Executive Committee for consideration and action.

3. **Adjournment:**

Upon motion made and seconded, it was voted to adjourn.

JOHN W. CLINE, M.D., *Chairman,*
GEORGE H. KRESS, M.D., *Secretary.*

CALIFORNIA PHYSICIANS' SERVICE*

Letters from Alameda County Medical Members; Reply Statement by C.M.A. Executive Committee; and other items in relation to prepayment plans for medical care.

I

Statement by 21 Alameda County Physicians

CALIFORNIA PHYSICIANS' SERVICE*

(Following statement by 21 Alameda County Doctors, was forwarded with request for publication in CALIFORNIA AND WESTERN MEDICINE. *Request was granted by the C.M.A. Executive Committee.)*

⁂

As a prelude to specific discussion of California Physicians' Servcie in its relationship to medical practice, it seems well to express a few generalizations. These generalizations probably are acceptable to a large proportion—we believe a majority—of Doctors of Medicine.

1. Freedom of Medicine is worth defending.

2. Freedom of Medicine consists of unimpaired doctor-patient relationship.

3. Medicine is more efficient, scientific, progressive, and economical when conducted as private enterprise.

4. Medicine must be defended from Socialization regardless of sponsor or avowed purpose.

5. Elements seeking Socialization of Medicine are aggressive and persistent. Our proper and effective response is intelligent defense, not apathy or collaboration.

6. The minimal requirement for preservation of Freedom of Medicine is open defense under responsible leadership.

7. Insurance, ably managed, can protect the patient by partial reimbursement without injury to Medicine.

C.P.S. was presented to the doctors of California as a plan to provide medical care for the so-called Low-Income-Group. Analysis revealed sufficient evidence to doubt the wisdom of the plan. Official State figures on income indicated that 91 per cent* of Californians were eligible. This proved that C.P.S. was not designed for any group but for virtually the entire population.

Would C.P.S. prevent State Medicine? There is not the slightest evidence that appeasement schemes discourage Socializers.

Is C.P.S. insurance? When Alameda County urged that C.P.S. be changed to insurance, which would protect the patient but in no way injure Medicine, we were told not only that C.P.S. is not insurance but that insurance was not intended. This is highly significant. Blue Cross and other hospitalization plans are true insurance. Hospital management insisted upon it. Insurance can apply to medical care too, if we insist upon it. Let C.P.S. be changed to insurance. It then would pay a specified sum for a specified service—but pay it to the patient. Let the doctor decide whether the sum is adequate compensation in each case. Nonprofit Insurance, ably managed, is likely of permanent success because it will be confidently patronized. This is evident from the success of the many plans now operated by private enterprise.

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* For editorial, p. 279; other comment follows.

* Commonwealth, May 27, 1941, p. 430.

It is now perfectly clear that C.P.S. as at present constituted is identical in theory and purpose with Socialistic schemes such as the Children's Bureau Plan, the Wagner Bill, and the Kaiser Health Plan. The essential in all is release of the patient from financial obligation to the doctor. An *agency* controls both cost to patient and fee to doctor and thereby attains influence over both.

The development of C.P.S. coincided with a surge of Leftism throughout California. With a trend toward Conservatism it is possible that pressure for such schemes may subside. But even were we to take the pessimistic view that Socialization is inevitable, yet we ask "Why accept Socialization while we still have the right to reject it?" We can keep Alameda County Medicine free if we will to do so.

Too prominent among the advocates of C.P.S. are doctors least affected by it, particularly doctors on salary at public and private institutions. It is the doctor in everyday practice who must endure the red tape, petty annoyances, chiseling, reduced scientific interest, reduced freedom, and reduced income.

If it be said that Alameda County is almost alone in rejecting C.P.S. and preferring to retain the freedom of private practice, let it not go unsaid that California is almost alone in having a State Medical Association attempt to impose such a scheme on its members.

C.P.S. was rejected by Alameda County after investigation and experience sufficient to learn its nature and its workings. But C.M.A. officials continually press us to rescind our action and permit C.P.S. to again take hold in our community. Needless to say, we are determined to keep our County clean. We will continue to reject C.P.S. until its conversion to insurance.

Let those who apologize for American Medicine be the ones to advocate Socialistic schemes. We believe American Medicine to be the most efficient, scientific, progressive, and economical in the world. But even more important—it is private enterprise by free men and women. Let Alameda County retain and defend that of which we are justly proud—traditional, honorable, *private practice.*

Above statement was submitted on October 17, 1944, by Sidney Parkinson, M.D., on behalf of the 21 Alameda County physicians whose names appear below:

Harry Templeton
Forrest Kracaw
Douglas Dickson
Dorothy Allen
Murphy Reeves
Roy Nelson
Dexter Richards
George Reinle
James Harkness
Gertrude Moore
Sidney Parkinson
Theodore Weller
Abilio Reis
Philip Dick
Fletcher Taylor
Charles Hall
O. T. Leftwich
Winfred Hart
Douglas Ream
Norman Leet
William Donald

PRIVATE PRACTICE

medical care →
Doctor Patient
← payment of fee

The natural patient-doctor relationship is reciprocal:

Medical care by the doctor—payment of fee by the patient.

PRIVATE PRACTICE PLUS INSURANCE

medical care →
Doctor Patient
← payment of fee

Insurance does not disturb the natural patient-doctor relationship.
Insurance benefits are paid to the patient.

↓ I ↑
Insurance

Insurance requires no special panel;
it recognizes the entire licensed medical profession.

Insurance Plans Pay the Patient * * * * * * * * Socialistic Plans Pay the Doctor

---

Children's Bureau

Wagner Act

Calif. Phy's Service

Kaiser Health Plan

These plans have their one *essential* feature in common: complete control of cost to Patient and fee to Doctor. This feature is the *trademark* of *Socialism.* It distinguishes Socialism from Insurance.

Socialism
fee ↑ S ↓ dues
Doctor Patient
medical care →

Socialistic plans invariably and characteristically usurp the financial transaction. Such plans may differ in all other features, but they never fail to aspire to be Medicine's fiscal agent.

Socialism generously grants free-choice-of-doctor. What it wants is control of the fee.

Control of the *fee* gives *control* of the *doctor* and of the practice of medicine.

Likewise, organizational control of the dues gives a measure of control over the patient.

Alameda County doctors reject C.P.S. until it is converted from *Socialism* to *Insurance* by the single step of paying the patient instead of the doctor.

II

Statement by 44 Alameda County Physicians

(Following statement was sent out by 44 Alameda County Physicians.)

* * *

Oakland, California, November 22, 1944

Dear Doctor:

Again the physicians of Alameda County are being asked to turn against California Physicians' Service. You have no doubt received a letter recently, bearing the names of twenty-one Alameda County physicians, urging that you send in your resignation as a professional member of C.P.S.

Some of us—and we have listed our names on this letter—have the feeling that a matter of this kind should properly come up through the regular channels of organized medicine. We have a County Medical Association, a State Medical Association and a Board of Administrative Members of C.P.S. We believe that these are organized for the purpose of providing checks and balances in the usual democratic manner and that no minority group of individual physicians should hold itself above these organized bodies in attempting to bring about changes in a going concern. As a matter of fact, the proposal now being made by this minority has twice been debated before the C.M.A. House of Delegates and defeated on both occasions.

At this time we do not wish to take issue with the statements made in that letter recently sent to you. Instead, it is our thought that the *method* of placing this matter before our members should be through regular channels, not in the form of a personal campaign. Then, if the will of the majority is made known, it is only fitting that all of us accept that verdict and guide our own actions accordingly.

We simply ask that you maintain your membership and keep an open mind on the subject of C.P.S. We suggest that defects in its present setup should be remedied in the democratic way and not through a revolution within our midst. The only effect of the revolutionary method is to create a vicious negative reaction on the part of the public, not only against the minority group fostering this attack but against the entire profession.

This letter is sent to you primarily in the hope of creating unity, not only within our county but within our State.

Fraternally yours,

C. L. Abbott
H. C. Aitken
K. W. Benson
Katherine Scott Bishop
Josephine Borson
George F. Calvin
Joseph D. Cieri
Leela S. Craig
H. W. Crane
Whitfield Crane
R. A. Crum
J. Lloyd Eaton
Grant Ellis
Arthur Fleisher
David Hadden
David Rodney Hadden
Dean E. Hart
E. Schulze Heald
James Hilgeson
T. Richard Hofman
S. A. Jelte
Percy H. Jennings, Jr.
George Kleeman
Harold W. Lambert
Elwood W. Lyman
Clifford W. Mack
H. Gordon MacLean
Oscar O. T. McAllister
Robert J. Oakes
Clarence W. Page
Ernest W. Page
Jane T. Paxson
Robert Redfield
Miriam Rutherford
Henry A. Shefoff
Paul R. Shumaker
Robert A. Stewart
Harold G. Trimble
Stanley R. Truman
R. G. Van Nuys
A. L. Velarde
Clyde T. Wetmore
J. Dwight Wilson
Lois S. Wilson

III

Council Chairman Gilman's Covering Letter to Statement by C.M.A. Executive Committee

This letter was sent to members of the Alameda County Medical Association, and to secretaries of component county medical societies.

* * *

Dear Doctor:

You were recently sent a letter by a group of physicians in Alameda County who expressed disapproval of the existing organization of California Physicians' Service and who asked that you express your opposition to C.P.S. by resigning your professional membership.

The views of this group of doctors are diametrically opposed by those of the California Medical Association, which has at all times been backing C.P.S. on the orders of its House of Delegates. The Council of the C.M.A. acts as the official body of the organization in between the meetings of the House of Delegates.

Enclosed you will find a statement prepared by the C.M.A. as an immediate reply to the statements made by the group of Alameda County doctors. A more complete reply will be published in the December issue of California and Western Medicine, along with the original letter. Meanwhile, you may well find the enclosed remarks worthy of your consideration.

We ask that you maintain your membership in California Physicians' Service and continue to give it your full support. Such defects as exist in California Physicians' Servce can be remedied in an orderly fashion by action of the House of Delegates while sitting as Administrative Members. One of the reasons that the House of Delegates was made the Board of Administrative Members of California Physicians' Service was to permit free discussion and action to insure that California Physicians' Service conform to the desires of the profession. This is the democratic process.

Fraternally yours,

Philip K. Gilman, M.D.,
Chairman of the Council.

* * *

IV

Reply Statement to Letter Signed by 21 Members of the Alameda County Medical Association

(Statement which follows is submitted by the Executive Committee of the California Medical Association.)

1. *Indemnity vs. Service.* The gist of the Alameda County complaint is that C.P.S. should be an indemnity insurance company engaged solely in reimbursing patients for all or part of the cost of professional services. As you know, C.P.S. was created by the C.M.A. as a medical *service* plan, and not as an insurance company. To set the record straight, the question of whether the medical profession's own plan should be an insurance company or a service organization has twice been voted down by the House of Delegates. At the special meeting in December, 1938, when it was voted to create C.P.S., the House almost unanimously rejected a proposal that C.P.S. be created as an insurance company. The idea of indemnification was unqualifiedly rejected for the reason, true then and still true, that the people want service, not a partial reimbursement of costs. Again in May, 1944, while the House of Delegates was in session in its capacity as administrative members of C.P.S., representatives from Alameda County introduced a resolution urging that C.P.S. be converted to an indemnity plan on

an insurance basis. This resolution was debated and rejected by the House.

2. *Public survey proves that cash indemnity doesn't satisfy public.* There was good reason for the rejection of a cash indemnity plan. This reason is a fundamental one. The people (and it is *they* who will untimately determine the future of the medical profession) do not feel that insurance cash reimbursement, leaving an exposure to additional bills, answers the problem of the cost of medical care. As stated by Dr. McCann, in describing the Massachusetts Medical Service, "Only a service contract for the entire family in the lower income brackets, under which no extra charge is made beyond the corporation allowance for the service, will give needed protection to this group." (A.M.A. Journal, Oct. 7, 1944, pp. 341-42). The public wants service without further exposure to burdensome expense, and one way or another it will get it.

3. *Service does meet demands of public.* To date, we know that a majority of the people are willing to vote against Government compulsion if they have available *service* from the medical profession on a reasonable prepayment basis. The independent and impartial survey made by Foote, Cone & Belding, with which you are familiar, definitely demonstrates that (1) a majority of the people in this state are not satisfied with private practice of medicine on a fee-for-service basis, (2) a majority of the people are, however, perfectly willing and desirous of having the medical profession do the job, if it does so on a service basis, (3) if the medical profession fails to do the real job, a majority of the people are perfectly willing to listen to politicians and vote for state medicine. It is our opinion that, in the light of the known views of the public, to convert C.P.S. to an ordinary insurance company would be a form of professional suicide.

4. *Instead of sabotage Alameda County doctors should again ask House of Delegates to decide.* If the group of physicians in Alameda County still disagrees with the reasoning of a majority of their fellow physicians, they should again seek debate in the House of Delegates, instead of sabotaging from the sidelines. The Association would welcome free and open debate on this subject once again in the House of Delegates, because it is confident that the course taken has been the only wise course, serving the best interests of the *profession and the public alike.*

5. *There is a difference between our plan (C.P.S.) and lay-controlled plans, public or private.* The physicians from Alameda County attempt to link California Physicians' Service with Government plans such as the Children's Bureau and the Wagner Act, and with lay-controlled private industry plans such as the Kaiser plan. One moment of reflection will demonstrate the fallacy in this approach.

What control does the medical profession have over the policies of the Kaiser plan? None, of course. What control would the medical profession have over Government medicine? None, of course. What control does the medical profession have over the policies of C.P.S.? The medical profession *owns* C.P.S. and is its sole control. The trustees of C.P.S. are elected by the administrative members. The administrative members are the delegates and alternates to the C.M.A. House of Delegates. Every member of the Association, through his delegates, is a part owner of C.P.S. The group in Alameda County has fallen into the error of considering C.P.S. *as somebody else's plan,* as some impersonal entity not connected with the doctors of California. Actually, and this is important, C.P.S. is not a third person or stranger or a company, it is you, it is *"our C.P.S."*, not *"that C.P.S."*

6. *C.P.S. has created an enormous good will towards California medicine.* Certain statements in the letter from Alameda County must not pass unchallenged. It is said: "Would C.P.S. prevent State Medicine? There is not the slightest evidence that appeasement schemes discourage Socializers." This is a non sequitur. It isn't socializers that C.P.S. is intended to impress or influence. It is the people of the State of California and of the Nation. C.P.S. has succeeded in influencing thought throughout the Nation far beyond what could reasonably be expected from its small size. It is favorably known in both Houses of Congress and is *not* attacked by any senator or representative, regardless of political party. C.P.S. is *not* an "appeasement scheme"; it is an effort to furnish real medical service on a prepayment basis and to do a complete job for the public. Cash indemnity, giving only partial relief from costs of medical care, is the *real* "appeasement scheme" and the public knows it.

7. *Blue Cross Plans are also service plans; they are not insurance.* In the letter from Alameda County it is stated: "Blue Cross and other hospitalization plans are true insurance. Hospital management insisted upon it." This is not a fact. Blue Cross plans are *not* insurance; they are service plans in which the hospitals underwrite hospital care in the same manner that professional members of C.P.S. underwrite professional services. There are today three Blue Cross plans operating in California. The extent to which these three plans actually call upon the hospitals to assume the ultimate financial responsibility under the service plan arrangement of the Blue Cross Commission of the American Hospital Association varies to some extent but the underlying principle of a *service organization,* not an insurance company, is inherent in the entire Blue Cross set-up. As a matter of cold fact, two of the three Blue Cross organizations in California today are engaged in litigation with the California State Board of Equalization, in suits which have as their purpose, among other things, to prove that these Blue Cross plans are engaged in a service business and not an insurance business. These suits in themselves are sufficient to refute the claim of the Alameda County physicians that "Blue Cross . . . is true insurance."

8. *Resistance to all change will kill, not preserve, private practice.* The letter states: "Let Alameda County retain and defend that of which we are justly proud—traditional, honorable PRIVATE PRACTICE." Needless to say, the California Medical Association has no objection to private practice, nor any desire to stifle it; but the Association begs to differ with those who think that by sabotaging C.P.S. private practice can be retained. They overlook the fact that the future of medicine is a matter in which the public as a whole will have something to say, and that the surest road to politically dominated medicine is to let the people feel that the medical profession with a head-in-sand attitude has only the desire to resist change and deny even the existence of an economic side to medical care. If we want to be engulfed and to lose *all private practice,* then by all means let us take the myopic view that all that we have to do is sit tight and defend "private practice."

9. *Service plans are not unique to California.* The letter from Alameda County states that California is almost alone in having a state medical association attempt to impose a prepayment service plan on its members. Granted that California was a pioneer in this field, it should be stated that Michigan followed California, that Massachusetts, New York, New Jersey, Colorado, and other state medical associations have now established pre-

payment service plans. In each state where thought has been given to the subject, the profession has chosen service rather than insurance.

In 1940 the Michigan Medical Association formed the Michigan Medical Service, which is comparable to C.P.S. Apparently whenever a majority of the physicians in a state undertakes a positive step in an effort to meet the problem of the costs of medical care, a minority within the profession, although out-voted, continues to attempt to defeat the will of the majority; for in Michigan, in spite of the success of the Michigan Medical Service, which now has over six hundred thousand members, one county has continually endeavored to kill the plan. In Michigan that county has not been successful.

10. *So-called trend towards conservatism.* The 21 doctors from Alameda County state: "The development of C.P.S. coincided with a surge of Leftism throughout California. With a trend toward Conservatism it is possible that pressure for such schemes may subside." It is aparent that the basic desire of the group from Alameda County is to stand pat and resist all change. It is also apparent that they think that the public trend is toward conservative resistance to change. To demonstrate that the group of doctors in Alameda County is engaging in wishful thinking, it is only necessary to refer to the national election held November 7th.

It doesn't take a great deal of perception to realize that the profession is not going to assist itself or the public welfare by timidly approaching the subject of costs of medical care, or by denying the existence of any need even to think about the subject.

(Signed) C. M. A. Executive Committee.

V

California Consults An Expert*

(Excerpts from an article in *Minnesota Medicine*)

Problems in distribution of medical services have been brought to a head in such states as California and Michigan as a direct result of the war.

Solutions which might have required many years of trial and error to evolve, have been forced into an advanced development, especially in California; and what has happened and is happening there may well be examined closely by doctors everywhere as a laboratory experiment in meeting issues which will eventually confront other states.

The California Physicians' Service, providing prepaid medical care to low-income families, had a slow and uncertain start some years before Pearl Harbor. The overnight growth of war industries, and the tremendous influx of workers occasioned by the war, presented problems in medical srevice which would not wait for solution. Leaders in organized medicine in the State made use of every available tool to keep from being overwhelmed. They expanded their California Physicians' Service, made unprecedented alliances with war plants, housing authorities and health officials in the hope that the delivery of medical services could be kept in the hands of private medicine and that government bureaus could be kept from stepping in and assuming the responsibility.

Profession Divided

In that respect, their efforts have so far been successful. But it is clear from published statements by officials of the California State Medical Association that the battle is not yet won in California, and that one of the hurdles has been the difficulty encountered in lining up the members, themselves, behind a united statewide plan of action.

The same difficulty has been encountered in many other states where initial experiments are now going on in the provision of prepaid medical service under medical association sponsorship. Misunderstanding, indifference and actual hostility on the part of individual physicians or component societies have threatened many another plan which had the wholehearted support of administrative bodies and association houses of delegates.

It is entirely in line with the pioneering spirit of the California organization that an interesting new step in solution of its difficulties has recently been taken in California. A capable and experienced public relations firm was asked to make a survey of the whole problem. The report of a representative of this firm, Mr. John R. Little, of Los Angeles, was presented recently to the California House of Delegates and is reprinted, here, in condensed form, from the July issue of CALIFORNIA AND WESTERN MEDICINE for two reasons. The first is that it provides an unique estimate by a qualified outsider on the social problem that confronts all medical organizations in these times. The second is that medicine's job today does not differ greatly in its public relations aspect from the job that has confronted many other groups in meeting the changing conditions of American life. It seems clear, therefore, that medicine will need the aid of such experts as Mr. Little, if it is to remain in control of its own house and avoid encroachment of government in the control of its essential functions. Minnesota has largely been spared the difficulties which are so acute in the delivery of medical service in California; but Minnesota doctors, also, should pay careful heed to the observations and advice given to their California colleagues in this report. The time is coming when they, too, may need such guidance. . . .

The highlights of Mr. Little's report follow. . . .

Plain Talks on Medical Care Insurance

(Reprinted from *New York State Journal of Medicine*)

PLAIN TALK, I

The medical profession of the nation is faced with a problem of great magnitude and importance. It must *sell* voluntary medical care insurance.

The House of Delegates of the Medical Society of the State of New York has provided for the establishment of a Bureau of Medical Care Insurance with a full-time director and staff to undertake this job for this State. That is all to the good.

Fortunately, this Society is already possessed of a Public Relations Bureau with experience and competence in presenting the views of medicine to physicians and the public alike. It must be used to capacity.

Also this Society has a JOURNAL. Its pages can tell a story. Those pages can tell the story of voluntary medical care insurance. They can tell that story to physicians who need to hear it. They can repeat that story in new words. Over and over. If they are used.

The Society is well equipped with tools for the job. Does it know how to use them? Time will tell. The Federal government knows how to use them. To sell what we consider an inferior product. Government-controlled medicine.

Many people sincerely believe that government medicine is good. We believe that voluntary medical care insurance is better. Our problem is simple. We must make more people believe that voluntary medical care insurance is better.

But first we must believe that ourselves. Enthusiastically and unanimously. You can't sell what you do not believe in; you can't expect the new Bureau of Medical Care Insurance to sell your insurance to people if you yourself do not believe in it. Certainly, it's your plan. Of course you know that it is medicine's answer to compulsory Federal insurance. You have read that time and again. You have heard it mentioned in your county society meetings—if you were there. You realized, naturally, that your various county and state societies' medical economics committees were "doing something about it." But what have you yourself done about it? Some things you can hire done. Others you must do yourself.

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* From the Department of Medical Economics. Edited by the Committee on Medical Economics of the Minnesota State Medical Association.

Excerpt is from "Minnesota Medicine," October, 1944, page 833.

If this JOURNAL is to serve you, and the common cause of medicine and the public interest, it must speak the truth. That is essential to good public relations.

Let's go! Not all of us believe enthusiastically in what we have to sell to the public. Some of us are hazy as to what it is all about. Therefore many of us can't talk to our patients or to the public persuasively and convincingly. So we say: get some one to sell the idea for us. That's a step in the right direction, but it is only a step. *Your* services are involved; *you* have to make any voluntary plan work; not only do you have to render the purely medical service to the subscribers, but you also have to do it enthusiastically. Otherwise you are asking your Bureau of Medical Care Insurance, your Public Relations Bureau, and this JOURNAL to help sell a gold brick, not only to the public but to other physicians.

This is plain talk. But we are committed to a voluntary insurance plan and it must work by virtue of the wholehearted participation of all of us in it.

"The people do not want Federal medicine," says Mr. John R. Little.[1] "They only want what they have been told *will result from Federal medicine*. The pressure groups and the politicians cannot enact Federal medicine without the clear will of the people . . . I suggest . . . you think only of what instrumentality you can supply which will satisfy the people's wants—an instrumentality which will be superior to anything politicians can offer. . ."

It will be, but only if physicians make it so. This does not mean *some* of the physicians of the State; it means *all* the physicians, and the proper use of *all* public relations media we possess.

* * *

PLAIN TALK, II

Many of us physicians are too preoccupied with the little trees of medicine to perceive the forest. We argue about details, procedure, and the like, endlessly, with each other. Thus we are prone to stress the differences of opinion which undoubtedly exist on many matters, while forgetting that we, the physicians, representing medicine, the public as the consumer, and government, the political agent of the people, are all in agreement as to the ultimate objective—better medical care for everybody. The people are interested in that.

We all want it. We all want it as soon as possible. The profession of medicine exists for no other reason than to provide it. The public rightly expects it from the medical profession—and gets it, by and large. Government can't do without it if it is to fulfill its constitutional pledge to promote the general welfare, of which the public health is a vital part.

The public knows something about insurance. It has bought billions of dollars worth of it, life, fire, accident, and the like, to its benefit.

Government knows about insurance, too. Because government is, after all, only the people when it does not forget and become biggity.

And the doctors, who are just people also, in spite of the language they use at times, are insurance-minded—couldn't carry on without it, in fact; life, fire, automobile, war-risk, accident, and all that.

So everybody is insurance-minded. And what is there to argue about? Spreading the cost? No; everybody agrees on that point. No argument. Ah! What are we proposing to insure against? The *costs* of *illness*. Sounds simple. Until you try it.

You can *assure* health only to a limited extent. That's preventive medicine and eugenics.

You can also *insure against* sickness. You can *insure against* the *costs* of being sick. If you know *how*, and *how much* the cost are and *how many* are going to be sick, and for *how long*. Plenty of room here for argument. Because you *have* to be right. You can't sell the insured people a gold brick. At least, not in this State. The law says so. If you promise something to people for fulfillment in the future, and people pay you in advance for delivery, you have to deliver just what you promised them you would. And, furthermore, people must be satisfied with what they get as a result of that promise which you made to them and for the fulfillment of which *they paid in advance*, often far in advance.

Now, you can pay off your insurance obligation either in services or in money. Some think one way is better, some think the other preferable. But in any event, you propose to meet *costs* of illness, and most plain people think of meeting *costs* with *dollars*. They understand that. Years of experience with life and fire insurance have taught them. Thanks to the businessmen, who have made this plain, reasonably simple, and prompt.

And so medical care insurance to meet the *costs* of unexpected illness must be financially sound, must pay where needed with as little red tape as possible, and must satisfy a need of the consumer, at a *price* he can afford.

The medical profession thinks it has had sufficient experience with the plans which have been in experimental operation in this State for many years now, to be able to say that such voluntary insurance can be provided for the public.

Eventually, government will assist in the operation and furthering of such plans, in our opinion, rather than to operate its own scheme of compulsory "health" insurance disguised as social security or whatever seems at the moment to be politically expedient because, after all, government is only the people and the people get what they want in this country.

Eventually the people will want the kind of medical care insurance of which the doctors approve, if the doctors will advise the people about it, because the doctors have always dealt honestly with the people and the people respect that way of doing things. But the doctors will have to inform the people by every means at their disposal of the advantages of voluntary prepaid medical care.

* * *

PLAIN TALK, III

There is one good point about being in agreement about something—you can go about your business expeditiously without wasting a lot of time squabbling.

Take voluntary prepaid medical care, for instance. There used to be some doubt and uncertainty about it; would it work? Did the doctors think it a good thing? How did the people feel about it? Would the medical profession support it? That was long ago.

Now the medical profession is squarely behind it, the public wants it, nobody opposes it who is sufficiently informed on the subject to know what it is all about. Take one aspect of it, for example. How can any plan to insure people against illness work unless the doctors are behind it? The whole principle of insurance depends upon *enough* lives, or houses, or automobiles of just plain people who pay premiums to meet the *cost* of the thing they *insure against;* in this case, *illness*. Next there must be enough doctors to treat the people, good doctors, too, or the people won't buy the insurance. Why should they put up with other than the *best* medical care? When they buy something they want the best that can be had. That is why the doctors themselves, through their Medical Society of the State of New York, are sponsoring voluntary prepaid medical expense indemnity insurance. That is why the Medical Society is setting up, right now, a Bureau of Medical Care Insurance with a full-time director so that the people can have the kind of insurance they want, backed by the doctors themselves. Such insurance is *safe* insurance.

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[1] California and Western Medicine, Vol. 61, No. 1, July, 1944, p. 12

Many of you remember the watch that made the dollar famous. It was good because it had responsible people and good workmanship and materials in it. Voluntary medical care insurance backed by responsible doctors is good for the same reason. Such insurance provides medical care of a quality that the doctors, through their State Medical Society, propose to furnish to those who want to buy insurance against illness.

It is not to be anticipated that you can start with a perfected plan. You can start with an actuarially *sound* plan, and you can set your upper limits of acceptance in a manner or at a level to include 94 per cent or thereabouts of all the people in the country. Then, after you have enough subscribers to your plan you can modify the details as may be necessary, and as accumulating *experience* seems to direct. But you certainly cannot go until you start.

Even though the people want prepaid medical care insurance it will take some time to cover 94 per cent, say, of the people of the country, or even of this State. Policies have to be written and marketed. So it's up to us to take the driver's seat and deliver the goods, isn't it? What is to stop us? Nothing that we can think of at the moment. Doctors have never yet been stopped from doing anything which they thought was for the public interest, and for the betterment of the public health, come hell or high water.

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PLAIN TALK, IV

Speaking before the Fifth District Branch Meeting of the Medical Society of the State of New York, at Utica, September 19, 1944, President Herbert H. Bauckus said, in part, "Man in his better moments has sympathized most hopefully with the proposition that all men are created free and equal. In the practical application of this thought is found again and again the strength and the faith that has nurtured our liberty—that has made America great. So, too, do we of the profession of medicine adhere steadfastly to the belief that all who live shall benefit alike according to the skill, ability, and resource of the highest developments in medical science available today. . . ."

President Bauckus called upon the responsible agencies of government charged with the responsibility of providing for the needs of the economically unfortunate to secure for these the same quality of medical care available to others.

"That this group, doubly unfortunate when ill, do not secure it, is not our fault—rather it is the result of the effort of the Boards of Social Welfare to buy cheap medical care. We do not want the product adulterated, no matter who pays for it. Political welfare medicine, cheap and hastily conducted school examinations, crowded and undersupplied clinics—we do not want them. Why do those outside of the medical profession insist that we shall have any such impersonal and poor medical care in this richly endowed America of ours? . . ."

Why, indeed? Because public business is that way in the nature of things; public officials, hard-working, ill-paid for the most part, some appointed for political reasons rather than for their knowledge, always under critical fire for their expenditures of public monies, are not in a position to do as they please. Restrictions laid down by higher authority govern, often under penalty for noncompliance of loss to the communities or districts or states of monetary grants-in-aid or rebates of tax monies. This is the curse of subsidy. This is the compelling reason why physicians look with disfavor upon the tendency to expand schemes for government or government-controlled practice of medicine.

"Our interest in preventive medicine likewise calls for the highest standards. We educate against epidemic disease, careless living, dangerous working—we warn against gambling with health and disease.

"Why do we need to have so many organizations to cope these many weary years with the problems of insanitation and preventable disease? I think a study of this question will reveal three main causes: (1) lack of leadership in the profession of medicine in public health procedures and their successful application to a properly informed people; (2) inertia and lack of carry-through to the use of our best medical knowledge on the part of officials of government—executive, law-making, finance, judicial; (3) health departments and boards of social welfare hampered by undermanned personnel, lack of funds, and political considerations.

"Our part, then, is to assume to the full our rightful leadership in the entire fields of the medical arts and sciences. No others are trained to understand or do as well. We ourselves do better. What does it profit anyone to keep with us this great preventable scourge, tuberculosis?

"I have no patience with those who quote statistics of 100 deaths being relatively unimportant when compared to 1,000 deaths. There is no place for coldness, and every place for warmth and mercy, in modern medicine."

Warmth and mercy, compassion, tenderness, the human relationship of one individual to another, the practice of medicine, or nursing? Can anybody visualize a Federal Warmth and Mercy Administration? A State Department of Compassion and Tenderness? The strength of government should lie in its impersonality, in even-handed administration of justice under the law, in the honesty and impartiality of its executives, in the incorruptibility of judges, in the accessibility of the courts of law to all.

Because there is this difference in the very nature of constitutional government and the practice of medicine, the government has no place, and, if constitutional, a government of laws, no sympathy, by definition, with the practice of medicine. It should have, quite properly, regulatory powers over the practice of medicine, provided these powers are wisely exercised under statutes which recognize the freedom necessary to the proper exercise and development of that which is partly a science and partly an art. But, as Dr. Bauckus says, leadership must come from within the informed profession. With assistance, not meddling, with lawful regulation, not control, by government. Failure by government to recognize these limitations, failure to exercise them, is to debase a profession, to demean government, and to substitute coldness for warmth, impersonality for a necessary humanism quite proper in the practice of medicine.

"To provide for the cost of medical care is a problem we have earnestly and considerately discussed with society in general and the individual patient in particular. We believe that our efforts to found voluntary prepayment medical care insurance plans in New York State are gradually bearing fruit. The establishment of a medical care insurance bureau with adequate personnel under the aegis of the Medical Society of the State of New York is a decided forward step, and evidence of our faith in the public appreciation of independent medicine.

"Any sane consideration of the cost must put hospital and medical care among the foremost needs. Food, clothing, shelter, medical care—they are essentials and not to be entrusted to the vagaries of chance. Our leadership must be constructive in the emphasis upon liberal public education in preventive medicine and the care of the mind and body in health and in disease. We cannot delegate our responsibility in this regard. . . ."

We have, however, much to learn. If we cannot delegate our responsibility, we must exert our authority within the profession to enlarge our plans for voluntary prepayment medical care insurance. Our own profession must be educated, and quickly, to acceptance of this responsibility and to the necessity for the widest possible coverage of the population. It is hardly practicable, even if it were desirable, to insure one-half the employees in an industrial plant. Which of us would insure one-third of his automobile or one-sixth of his house?

Public appreciation of independent medicine seems to be evidenced by its support of the practitioners and the institutions of that kind of medicine. But there is much danger of alienating public support and confidence by too great independence. There is a happy medium and we would do well to take public need as a criterion and proceed accordingly.

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* Public Relations Bureau of the Medical Society, State of New York, 292 Madison Avenue, New York 17, N. Y.

On Impending Federal Legislation—Wagner-Murray-Dingell Bill

*A Letter from Lowell S. Goin, President of the American College of Radiology to its Members.**

(COPY)

THE AMERICAN COLLEGE OF RADIOLOGY
540 North Michigan Avenue, Chicago 11

November, 1944.

Monthly News Letter, Number Thirteen

Dear Doctor:

. . . The normal functions of the College are now being resumed, and the officers have plans that will increase the scope of its activities and make its program of even greater value to the specialty of radiology and its practitioners in the years to come. The coöperation of the entire membership is needed for the immense job ahead of us.

We are living in a period of great social and economic change, in times which, even though trying, are of tremendous interest. Greatly affected by these changes, and struggling to adapt itself to them is our own profession of medicine. The problem is complicated by the natural resistance offered to change by all living things, and by the far reaching implications of the changes proposed.

What is about to happen to our socio-economic world? What may be done about it? Can these changes be stopped? Should they be stopped, or only guided? These are questions which are presently occupying the minds of a very large number of thinking people, and the answers are not readily given.

Many of us think that we are in the grip of great social forces whose power and strength have been gathering for years, perhaps for centuries. Progress consists essentially of changes, and our chief error lies in assuming that change is necessarily bad, on the one hand, or on the other that all changes represent progress. Truth lies between these two views. Changes are occurring, and are going to occur, in many aspects of life, but that change which most concerns and interests us is in the methods of the distribution of medical care.

No thoughtful person can deny that there are grave faults in the system by which medical care is now distributed. No thoughtful person can agree that an ideal method has yet been devised. Agreement is nearly unanimous, however, that the solution does not lie in socialized or Federal medicine. Those who do so believe are simply refusing to look at the facts accumulated by the European experience with medical care thus administered.

In spite of these considerations, it is by no means impossible that socialized medicine will come upon us, if not as proposed in the Murray-Wagner-Dingell Bill, than in some other fashion. If this be the case, it behooves us to consider what the position of radiology may be when our social planners have brushed the star-dust from their eyes and have settled down to the solid and practical matters of votes, patronage, and dollars to be gleaned from their welldoing.

The pending legislation is by no means dead, or even dormant. Hearings were held last month at which several of our leaders testified. Dr. Roger Lee of Boston, President-Elect of the American Medical Association appeared, and made a most favorable impression on the Senate Committee, and for this we should all be grateful.

The language of this proposed law has a certain vague grandeur coupled with a murky character which makes it nearly impossible to be sure just what the authors intend, but centers with diagnostic facilities are mentioned fondly. Since it seems unlikely that it is intended to erect centers to house a doctor with a stethoscope, one might assume that the diagnostic facilities referred to will be radiological and clinico-pathological. This, of course, would very neatly dispose of the private radiologist. Although the disappearance of the private radiologist is a small matter in comparison with the catastrophic effect of such legislation upon the public health, it nevertheless has some interest for us. We have, then, a triple duty: first, (and smallest) the guarding of our own specialty and the prevention of the loss of its benefits to mankind. Second, to assist in the defense of the medical profession (our medical profession) against its own destruction. Third, (and most important) to prevent the lowering of health standards and the increased death rate which will inevitably follow the enactment of such legislation.

Toward that end we have but one course now apparent, and that is the encouragement and support of voluntary medical care plans. I have already referred to the natural tendency to resist change, and I must now remind you that it may be stated as an axiom that whenever the people find beyond their reach something that they think should be available, the people will always make that thing available. Voluntary, physician organized and operated, medical care plans can solve the problem. Such plans *are* beginning to solve it, and the purpose of this message is to urge the radiologists of America to encourage and actively support these plans.

Sincerely yours,
(Signed) LOWELL S. GOIN, M.D., F.A.C.R.,
President.

In the "Paradise of Wisdom" by Ali Ibn Rabban, a work dealing with medicine, philosophy, embryology, psychology and astronomy, mention is made of elephantiasis, lupus and cancer.

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* Dr. Lowell S. Goin is president of the California Medical Association. His letter to fellow-radiologists should be of equal interest to members of the California Medical Association.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Dec. 19, 1944.

IMPORTANT NOTICE

U. S. NAVY WANTS YOUR HELP

Medical Department of the United States Navy has urgent need of 3,000 additional surgeons.

Our Navy is understaffed by about 7,000 physicians.

Coöperation of every California physician is urgently requested.

From "Men at Worst" to "Men at Best"

California Surgeon Meets Amazing Heroism

From the confines of San Quentin's high walled prison for 28 years, Dr. Leo. L. Stanley, chief surgeon and at times acting warden, saw "Men at Their Worst." His popular book a few years ago carried that title.

Dr. Stanley, now a commander in the Navy and just returned from three years of sea duty—much of it aboard a hospital ship in the fighting areas—knows what title would be appropriate for another book, should he decide to write one. It is: "Men at Their Best—the Story of Bluejackets and Marines at War."

For more than a score of years, Dr. Stanley witnessed men at their worst in an institution provided by society for those who broke the rules of the game. Some of them despaired, some lost hope. Sometimes on the operating table a man openly wished to die; sometimes life in San Quentin Prison wasn't worth fighting for.

Now, 32 months after the Pearl Harbor attack, when Dr. Stanley was called to active duty, the former San Quentin surgeon has seen men fighting for their lives on the operating table when the odds were stacked against them. . . .

His ship was in the Kwajaleins during the battles for Roi and Namur; it was at Enjwetok, Saipan and Guam.

It arrived at Saipan on D-Day plus two. . . .

Dr. Stanley recalls a time in the Saipan invasion:

"We had come down from Saipan with hundreds of patients, many of them seriously wounded. It took us a week to make the trip and all of us had been tense during the four days we had stood by to receive these patients with the battle going on before our eyes.

"For some there was little sleep. Surgeons were busy day and night."

Many surgeons, he said, handled more than 30 operations in a day.

"Speed and prompt surgery," Dr. Stanley says are the key to medical action. Sometimes it required more than medical science and prompt surgery to save a man's life; it required the patient's own tenacity and nerve, a willingness to stick it out and see it through. Once in a while a man's arm or leg had to be amputated and a man had to be of iron to watch it. These Army, Navy and Marine Corps men, Dr. Stanley says, were "Men at their best."

Life aboard a hospital ship, while interesting, wasn't always easy. When the seas were high and the ship tossed, a surgeon would wrap a leg around the operating table for support. And yet nothing deterred from prompt ministering of men.

The ex-San Quentin surgeon had words of high praise for Navy nurses, who, he said, for the most part are capable and efficient, and add a lot to the morale of the patients on board.

"Nurses are in great demand," he said.

And he was emphatic in pointing out the importance and necessity of blood plasma which oftentimes saves wounded men's lives even before they are transferred to a hospital ship or to a hospital base.

The Services Need More Nurses

Although more than 35,000 nurses are now serving with the Army or Navy, the need is by no means satisfied. During the next year it is estimated that something like 30 000 additional nurses will be required. Including 35,000 students now in training, the number of nurses available for service with the Army or Navy is estimated at about 195,000. In recent months the rate of enlistments has fallen off, and the Army and Navy Nurse Corps is making an effort to convince more nurses that their first duty in this emergency is to serve the sick and wounded among our fighting men.

Of course, this need puts a new strain upon civilian hospital staffs, already on desperately short rations, and the call for girls to study nursing and for women to take Red Cross courses in home nursing or to qualify as nurses' aides is increasingly urgent. The *Post* is glad to add its endorsement to the appeal of the services and the Red Cross for an increasingly large number of women with the necessary age and educational qualifications to contribute their skill and patriotic endeavor to meet the crisis in the care of sick soldiers and sailors and of the civilians who are left behind.

Draft Statistics on Physical Defectives

"Facts uncovered by the war concerning the physical unfitness of the men of this country are beginning to have their first repercussions. A Congress committee is exploring the situation revealed by physical examinations for the draft. Out of that exploration very probably is to come a renewed demand for broader Social Security—disability insurance, hospitalization, maybe a start toward state medicine for persons other than war veterans."

This paragraph, from the *United States News* of July 21, expresses the theme of several national magazines in recent weeks. The attitude is that because draft rejections have been high, state medicine is the only solution. Continuing, the *News* points out that at least 15 to 20 per cent of the ailments for which men have been rejected could have been corrected. It is conceded, however, that malnutrition may have been a major cause of bad teeth and tuberculosis. Mental disorders are so widespread, it is stated, that more than 30 per cent of the men rejected have mental diseases or mental deficiencies including illiteracy. Ten per cent have been rejected because of such manifest defects as missing arms or legs, blindness, and deafness. Syphilis and other venereal diseases have caused the rejection of 7.1 per cent. Heart ailments, tuberculosis, visual disturbances, and bad teeth are among the other leading causes for rejection.

Admittedly then, 80 to 85 per cent of the defects which have caused rejection by the military were not amenable to medical or surgical treatment. They were caused in large part by poor heredity, malnutrition and bad environment, neglect of teeth, fractures, deformities, and many other conditions which might have been corrected early in life. The constantly repeated assertion that clinics operated by the government would have prevented such widespread physical disability has small basis in fact. The poorer districts of all important cities have long had large charitable clinics where the finest of medical and surgical care was available to that part of the population who were unable to obtain it privately. No amount of medical care can overcome the effects of ignorance, indifference, poor nutrition and bad housing. . .

If our government is sincerely desirous of improving the health of the nation, it will adopt a policy of universal slum clearance, and will provide proper recreation and playgrounds for city children. Instead of destroying food surpluses it will see that every child is properly fed. Every youth will be instructed as to the dangers of venereal disease and as to proper methods of treatment thereof. It will provide care for persons afflicted with tuberculosis and other prolonged and catastrophic illness. It will build fine municipal gymnasiums, swimming pools, and athletic fields in every community, and will encourage all children and young people to participate in athletic programs, rather than reserving participation for a small percentage of super athletes who do not need such training. Through a system of loans and subsidies it will be made possible for people of small means to obtain medical and dental care from private sources in a self-respecting and American manner.

These, and related measures, within one generation, would correct most of the defects which have caused such a high rate of rejection by the armed forces. The cost will be great, for it is expensive to eliminate slums, eradicate malaria, and carry on great mass educational programs. It is far easier, and more in line with standard political thinking, to establish some clinics, put more doctors on the government pay roll, and ignore the great basic evils which have been so startlingly revealed by the draft.—E. T. Remmen, Secretary, in *Bulletin* of Los Angeles County Medical Association.

General Kirk Addresses Military Surgeons

Major General Norman T. Kirk, the Surgeon General, made the opening address at the 52nd Annual Meeting of the Association of Military Surgeons in New York City this month. He outlined briefly the progress made by the medical profession in this war, which, he stated, had advanced medicine fifteen years. He then went on to say that the responsibility of the Army Medical Department did not end with getting soldiers well quickly and soundly but extended to giving those returning to civilian life "every possible aid to get them back on their feet." This, he explained, meant preparing them to return home and resume their normal way of life. General Kirk then called on the military surgeons to help educate the public on how to receive these men, the majority of whom, he said, want to be considered as self-reliant human beings and want a job—not a lot of sob-sister sympathy.

Critical Need for Army Nurses Continues

Out of 27,000 recruiting letters sent by the Army Nurse Corps to nurses classified as 1-A for military service by the War Manpower Commission, only 710 replies have been received, and less than a third of these are from nurses qualified for commissions.

While the drive to recruit Army nurses lags, the number of patients being evacuated from overseas to the United States has been increased almost 300 per cent. In addition, the overseas requirements for nurses continues to grow, with the quota for the month of December alone set at approximately 1,000 nurses.

Social Security Tax: Freeze Continues

One Per Cent Levy to Continue; President Roosevelt to Submit a New Plan

Washington, Dec. 16.—(AP.)—President Roosevelt's "reluctant" signature on legislation freezing Social Security taxes started a general congressional exodus from Washington today. Except for some State Department nominations under fire in the Senate, the social security legislation—blocking a scheduled increase from 1 to 2 per cent in pay roll and pay check taxes on January 1—was the last major hurdle between the 78th Congress and its final adjournment.

Announcement of the President's action drew a burst of applause when Speaker Rayburn made it in the House, where members generally had expected a veto.

There were less than 100 representatives on the floor at the time and many of them scooted away promptly to take up train and plane reservations for home.

Roosevelt's Statement

With only a few noncontroversial odds and ends in addition to the Senate nominations to be acted on, leaders set their sight for final adjournment not later than Wednesday.

Rayburn's announcement of the President's action was followed by White House release of a formal statement declaring it would be incumbent upon the next Congress to review thoroughly the methods of financing social security benefits.

The President said he still felt that the tax should have been allowed to rise on account of "Long run requirements of the Social Security System." He asserted the measure "Merely defers until next year" the necessary fiscal receipts. He added that it did not seem "Wholly sound to enact a tax law and then defer the taxes year after year."

"At an early date," the President said in the statement, "I plan to submit to the Congress a comprehensive plan for broadening and improving the Social Security system." . . .—San Francisco *Chronicle,* December 17.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Calls Bill Dangerous

Says Passage of Wagner Bill Would Foist Collective Medicine Upon America

"Political medicine as proposed in the Wagner-Murray-Dingell bill is too dangerous a trial balloon to launch upon the American people," Dr. H. Clifford Loos, head of the Ross-Loos Medical Group, told a representative of the Underwriters' Report in an interview on the prospects of socialized medicine and of alternative plans now being advanced from within the medical field.

"When the American farmer is desirous of going into collective farming, and when American business men desire to go into collective business ventures, and when America decides that the free enterprise and competitive system upon which this country was founded is no longer desirable, then will be the time for the collective practice of medicine operated by the government," he declared.

"We haven't reached that state yet, and if I know America we will never reach such a social status. Collectivism is not American, and it would be unfair to saddle collectivism on one segment of our population, namely the doctors, and not include all of our citizenry in it. The doctors who are having to render the medical service should have something to say about how it is to be done, and we do not want political medicine.

"We in our profession are not as unprogressive as the reformers would picture us. We sense the need for doing something, and we are doing something. If the Government will leave us alone we will solve the problems. There is evidence all around us that the solution is near at hand. Who is better able to work out this puzzle than the doctors themselves? The passage of such a bill as is now before Congress would be such a hopeless thing for the medical man. The doctor does not want to be on a fixed income with no reward for merit, and because he would so unwillingly go into such a system of practice, the type of medicine practiced would be bound to deteriorate, and those who would be bound to suffer in the long run would be the patients of such a revolutionary scheme.

"When we talk of a better spread of medical care for the American people, what people are we speaking of? More and more, Government in this country has usurped the old private practice field. Already we have the industrially injured and sick treated by mandatory coverage. So this group has been taken away from private practice. All veterans of the wars receive medical care at the hands of the Government. Government has taken care of the insane and the tuberculous. Communicable diseases if institutionalized are cared for at public expense, and venereal diseases can be treated through public health agencies. Indigents, of course, are provided care. We are talking about medical care for those left out of these special categories.

"Of course many of our people who are eligible for medical care at public expense do not accept it. Most of the veterans of the last war choose to seek medical care through other channels than governmental agencies, and the fact that private tuberculosis sanitariums still thrive shows that government does not handle all tuberculosis cases. There will always be many of those eligible for governmental care who will not choose to accept it, and whose choice will be of their own selection."

Dr. Loos came to San Francisco to address the Commonwealth Club at a meeting on September 15.—San Francisco *Underwriters' Report.*

Social Security

House Committee Favors Tax Freeze

A poll of the House Ways and Means Committee indicated on November 29 it will vote, 15 to 8, tomorrow to "freeze" the Social Security tax, scheduled to double automatically on January 1.

Republican Leader Martin of Massachusetts said that all who expressed themselves at a meeting of the party steering committee late today also were in favor of the freeze, forecasting a heavy G.O.P. vote to that end.

However, some leading proponents of the "freeze" conceded the Presdient will promptly veto the measure if Congress passes it. They added that there are not enough votes to override a veto.

In that event the tax will be boosted a month hence from 1 to 2 per cent—meaning that the wage and salary man will pay the security fund $2 for each $100 he earns (up to $3000) and the employer will pay $2 on each $100 of his payroll.

A check of Ways and Means members indicated that six Democrats are inclined to vote with nine Republicans, to brush aside Administration recommendations and put thruogh the "freeze" bill. Eight Democrats probably will vote the other way.

There still is a possibility of overnight changes.

Congress was told today that leaders of organized labor want the security tax to double, as provided in the basic Social Security Act.

Martin H. Miller, legislative representative of the Brotherhood of Railway Trainmen, testified before the committee that his organization vigorously opposed the "freeze," and that he is advised that CIO and AFL leaders have the same view.

He said the increase "is absolutely necessary for a sound Social Security system. Otherwise, Congress later must subsidize the security fund with direct appropriations from the general revenues."

A representative of numerous industrial groups has pleaded for the "freeze," contending that the size of the security reserve fund is ample.

* * *

Wider Social Security to be Proposed

The Administration disclosed on November 27, it will present to the new Congress a proposal for vastly expanded social security coverage.

The disclosure was made even as the Administration encountered a burst of opposition in formally asking Congress to let the social security tax double on January 1, as provided by law.

A. J. Altmeyer, security board chairman, took the Administration's views before the House Ways and Means Committee.

Committeemen submitted him to vigorous questioning, indicating opposition to the tax increase, and causing speculation that Congress might vote to "freeze" the tax at 1 per cent.

Altmeyer said the increase to 2 per cent (against the pay of employee and also against the payroll of employer) is necessary for a sound social security program. He declared "the issue is whether Congress is going to make promises (of security) and not provide money to make good on these promises." If taxes are not increased, he warned, it may be necessary later to subsidize the program through direct appropriations.

Obligations are being created faster than reserves, he continued, although the obligations in large part will not fall due for 20 years.

Expansion Plans

The security board chairman then told the committee he would be back early next year with proposals for vast expansions.

He later gave a reporter a brief outline as follows:

1. Social insurance—A comprehensive system of compensation for part of the involuntary loss of earnings suffered by workers due to sickness and disability.
2. Old age and survivors' insurance—Coverage to be extended to agricultural workers, domestic workers in private homes, employees of nonprofit organizations and self-employed persons.
3. Administration of unemployment insurance, now in State hands, should be made a Federal responsibility.
4. *A Federal system of medical and hospitalization benefits.*

Altmeyer indorsed the Wagner-Murray-Dingell social security bill "in principle, but not in all detail." Dingell (D., Mich.) said the medical program in his bill "is not socialized medicine."

The plea that the social security tax be allowed to rise met with a cool reception by some committeemen. Representative Knutson (R., Minn.), committee Republican leader, said it seemed to him Altmeyer was "pleading for the increase so the Government will have more money to spend."

Chairman Doughton (D., N. C.) asked Altmeyer why "you missed the mark so far previously" in estimating the yield of the social security tax. The witness blamed the war and revisions in the act.

R. T. Compton of the National Industrial Council asked the committee to "freeze" the tax at 1 per cent, saying employers and employees could "save" $9,000,000,000.

Representative Gearhart (D.-R., Calif.), committee member, said: "I believe it is revenue the Government is after, not money for old age pensions."

How Attempt to Regiment Holland Physicians Failed*

Translation of a letter addressed by the Netherlands physicians (and surgeons) to the "Rijkscommissaris voor het bezztze Nederl. Gebied" (Dr. Seys Inquart)

(COPY)

"It is with the greatest astonishment and indignation that we, Netherlands physicians (and surgeons) have taken notice of your latest instructions regarding the exercise of our profession. These instructions state among other things that doctors are no longer at liberty to lay down their profession, or to resign and give up the titles denoting their qualifications. This involves that you are again trying to force them to become members of the 'Artsenkamer' (a branch of the *Nat. Soc.* Medical Society). Those who should act contrary to your instruction are threatened with severe punishment.

"For generations we, Netherland physicians (and surgeons), have worked for the well-being of our patients and of this people. A high standard of medicine and hygiene has always existed in the Netherlands thanks to our practical and scientific labour.

"Our organization 'De Nederl. Maatschappij tot Bevordering der Geneeskunst' (the Netherlands Medical Society) was a 'trade-union' of the highest order. It worked according to the Netherlands standards and traditions, and its membership extended to practically the whole of the Netherlands medical profession. Of our own free will we have all resigned from our excellent 'trade-union' in order to prevent it being used as an instrument for terrorizing the Netherland medical profession.

"You then founded the 'Artsenkamer' which was to force upon the doctors the Nat. Soc. principles that are so absolutely and entirely alien to them.

"Mr. Rijkscommissaris, you should be well aware of the antagonism of the medical profession against this imported institution which is being imposed upon them. During the time of its existence the 'Artsenkamer' has time over and again come into conflict with the medical profession as a whole, and none of its aims have been attained so far, owing to spontaneous resistance. The organization has been and is greatly mistrusted by all Netherland doctors. You will remember having received in December, 1941, a letter, signed by 4,500 doctors, with the request to abolish the idea of founding an 'Artsenkamer' with the object of imposing Nat. Soc. principles in the region of medicine. The following out of the principles of racial prejudice, with its consequences of the elimination of lunatics and invalids and the sterilization of healthy people, shows in how far our solicitude was justified. Evidence of how the 'Artsenkamer' is opposed to the spirit and the feelings of the Netherland doctors was recently produced by the resignation of 6,200 doctors who decided rather to give up their profession than to join the 'Artsenkamer.' In spite of this, you are once again trying to enforce upon us, through a display of your power, the things that we are unwilling to do, and you are endeavoring to put us under the guardianship of a small political party which enjoys neither our confidence nor our esteem.

"Mr. Rijkscommissaris, the doctors come under your latest regulations because of the oath they have sworn when taking up their profession. It is on account of this very oath which implies certain medico-ethical standards, that it will be impossible for us in the future to comply with your wishes. Should the moment arrive that we doctors are to be faced with inacceptable demands, it may prove necessary for us to venture our lives and our freedom, and to challenge your threats.

"We hope we shall be spared such a conflict, and that we shall be allowed to continue our work conscientiously in freedom and in peace.

"Further developments in this matter depend entirely on you, Mr. Rijkscommissaris, and you will be held responsible in the presence of the Netherlands People."

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* Covering Letter for Item follows:

(COPY)

COLLEGE OF MEDICAL EVANGELISTS
Clinical Division
White Memorial Hospital
December 14, 1944

George H. Kress, M.D., Editor, addressed.
Dear Dr. Kress:

A short time ago I received a letter from one of our alumni, Dr. ———, who is on military duty and is now located in Holland. In his letter to me he enclosed a translation of a letter addressed by the Netherlands physicians to a Nazi appointed governer, and because I thought you might be interested in this document, I had my secretary make a copy, which is enclosed.

This was given to Captain ——— as a souvenir by a doctor in a little Netherlands town. It was typed and translated by one of the secretaries in the local branch of the medical society. Dr. ——— adds that the doctors eventually had things their own way and that they were the most unanimous of any group in Holland in opposing the things which the Nazis were attempting to require of them. He states: "Also, they were the only group that was able to take an open stand and not lose their necks. For this reason they were able to do much good for the people during the occupation."

If you think you can use any of this in the CALIFORNIA AND WESTERN MEDICINE, you are free to do so.

With best personal regards, I remain,

Sincerely yours,
(Signed) W. E. MACPHERSON, M.D.,
President.

December 20, 1944.

To All Members of the California Medical Association:

Dear Doctors:

I feel that you should know that Labor intends to introduce into the January session of the State Legislature a bill providing for the establishment of compulsory health insurance in California. The exact nature of this bill is not known.

Your officers of the California Medical Association have had some discussion with representatives of Labor who express willingness and indeed, eagerness, to coöperate with the doctors of California in making the most workable and least objectionable bill that can be drawn.

If the Legislature does not enact the bill into law it is understood to be the intention of Labor to take the matter to the people by the initiative in the general elections of November, 1946.

Because of the gravity of these impending events your C.M.A. Council is calling a special session of the House of Delegates to meet in Los Angeles on January 4, 1945, and the purpose of this letter is to urge you to try to attend that session. While only members of the House of Delegates may participate in the debate and actions of the House, every member of the Association is welcome to attend and I wish to urge you to do so if it is at all possible.

Your entire future may be affected by the actions taken by the C.M.A. House of Delegates in this session and it will be to the benefit of Medicine in general and to your personal benefit if you can attend and hear the matter presented and debated. I hope that you can do so.

Very truly yours,
(Signed) LOWELL S. GOIN, M.D., *President.*

Physicians Seek Place in Cabinet

An official of the American Medical Association recently declared the time has come for the medical profession to press for specific action on the creation of a national health agency "with a secretary of Cabinet rank."

Such an agency, said Dr. John H. Fitzgibbon, chairman of the A.M.A.'s council on medical service and public relations, would coördinate and administer all medical and health functions of the Federal Government exclusive of those of the Army and Navy. He said the profession long has advocated it.

(Editor's Note. In 1872 at the meeting of the American Medical Association, Dr. Thomas M. Logan who founded the California State Board of Public Health in 1870, advocated a National Health Council and in the 42nd U. S. Congress of 1872 recommended the establishment of a National Department of Health. Quotation from his statement follows: "Let us have a Secretary of Public Health, as well as a Secretary of War." For references see CALIFORNIA AND WESTERN MEDICINE, January, 1940, pages 2 and 6.)

He told the District of Columbia Medical Society formation of such an agency could be followed by discussions with the medical profession and other groups to determine "the necessity for and nature of federal action" to make high-quality medical care available to every person in the United States.

The doctor said the A.M.A. long has had the objective of the continued development of private practices, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability "including the development and extension of voluntary hospital insurance and voluntary medical insurance."—San Jose *Mercury Herald*, October 9.

Fellowships for the Training of Health Officers

The Commonwealth Fund has arranged for the training of health officers and the following conditions have been set out:

Eligibility—Length of Tenure

1. All applicants must possess a medical degree, have had at least one year's internship, and have shown ability, together with interest in and aptitude for public health.

2. Men who have had at least a few months' experience in actual public health work will be preferred.

3. Applicants without any experience in public health must have exceptional ability and if awarded a fellowship will be provided a full calendar year so that they may have opportunity for some field training either before or after their course of study.

4. Applicants who have not attended a school of public health will be preferred and the fellowships will be awarded for one school year except as indicated in number 3 above.

5. Applicants who have attended a school of public health for one year will be considered for a second year, for the doctorate, provided there are available fellowships.

6. A total of six fellowships will be available the first year.

Stipends

Single men—$175 to $200 a month, depending upon circumstances; plus tuition and travel from home to school and return.

Married men—$200 to $250 a month, depending upon individual circumstances; plus tuition and travel from home to school and return.

Procedure for Application

1. Application blanks and accompanying papers must be filed with Commonwealth Fund, which reserves the right to require personal interviews if it is deemed necessary.

2. Awards made by the fund will be subject to acceptance by the school of public health concerned.

3. Schools at which these fellowships will be tenable are:

Johns Hopkins University School of Hygiene and Public Health.

School of Public Health of the University of Michigan.

DeLamar Institute of Public Health of Columbia University.

Graduate School of Vanderbilt University.

School of Public Health of the University of North Carolina.

Physicians who are interested in the fellowships should obtain application forms from Dr. Clarence L. Scamman, the Commonwealth Fund, 41 East Fifty-seventh Street, New York 22, New York.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Blue Cross Hospitalization Growth

One of the Nation's greatest social health experiments, the Blue Cross, which is the united title for 80 American hospital care associations, passed the 15,000,000 membership mark this summer.

The Blue Cross also cleared the last barrier to admission of every American to hospital insurance. This was done by arranging for community welfare organizations to sponsor memberships for persons who lacked industrial sponsorship; employees of firms with less than 10 persons, domestic servants, the self-employed, many professional people and the retired.

The real membership this summer is nearly 16,000,000 if the count is spread to the service men and women whose enrollments are held open during the war. The rush of new members brought in almost 2,000,000 the first six months of this year. There has been no slackening since.

The Blue Cross covers 41 States and the District of Columbia. The seven States without Blue Cross service are Arkansas, Mississippi, South Carolina, Idaho, Utah, Wyoming and New Mexico.

In the Blue Cross are 3000 hospitals, which contain five-sixths of the Nation's total bed capacity for acute illnesses among the general public. Not in Blue Cross are about 2000 Federal, State, city and county hospitals, primarily for the indigent and for mental and tuberculosis cases, and about 1000 small proprietary hospitals.

There are five Blue Cross plans in Canada and one in Puerto Rico, which are counted in the American total of 80. Membership is available in areas representing about 95 per cent of the Nation's total population.

The first hospital service plan began in 1929 at Baylor University, Texas, for 1500 teachers. Inside two years there were several similar plans. Use of the name and symbol, Blue Cross, was started in 1933 by E. A. Van Steenwyk, then manager of the Minnesota plan, now executive director of the Philadelphia Blue Cross.

In the early years the main problem was actuarial, that is, whether the principle of providing hospital care for a fixed annual charge was sound, and precisely what it must cost. This hospital care is neither commercial, like life insurance, nor political like government insurance, but a cross between. It is not commercial because no profits are permitted. It is something new in large-scale American social development.

The idea of family coverage was new. Almost everyone said it could not be done. Including maternity care was considered the rarest folly. In retrospect, the public was not particularly concerned with the price, but wanted to know whether hospital insurance was worth anything at all.

That is past. The main problem now is public relations and administration. The two combine to keep this huge, sprawling, free-will organization at an efficient and growing peak.

Letters from clients run into thousands, mainly laudatory. The common denominator of these praises is the increased sense of security.

In 1937, Julius Rosenwald of Chicago, allotted a grant of $100,000 to the American Hospital Association for study of hospital care and related problems. Afterward various Blue Cross plans, as each hospital plan is known, began to contribute to the parent body.

Now the American Hospital Association has, all from these plans, an annual budget of $70,000 for the hospital service work. Dr. C. Rufus Rorem is director of the Hospital Service Plan Commission, with headquarters in Chicago.

The hospitals in the plans report an increase in patients due to the Blue Cross movement, but without more overcrowding, because the length of stay is shorter. Blue Cross subscribers are hospitalized promptly, before they become so ill.

Women have been found to require about 50 per cent more hospitalization than men. There were 200,000 Blue Cross babies last year. Epidemics have not seriously affected the Blue Cross, although they have crowded hospitals occasionally for a month or two.

Removal of the last barrier to universal participation was typical of this voluntary social advance. It began small, scattered itself widely, and then turned into snowball proportions. One of the first community-guaranteed membership plans began in 1938 in Stillwater, Minn. Seventy-five per cent of the population joined.

Gradually this idea spread to 128 cities and towns in 20 States, with Haverhill, Mass., 46,000 population, the largest.

For its part, the Blue Cross sets up standards. These are not rules with precise limitations, but broad requirements, such as non-profit organization, assurance of good medical care, that the public interest shall be served, free choice, limitation to hospital charges and dignified promotion.

Last year the Blue Cross plans paid $70,000,000 in hospital bills, nearly 20 per cent of the income of the member hospitals. A Blue Cross member was said to enter a hospital every 20 seconds. And this was not higher than the average for all Americans. The membership then was one in every 10 Americans. Some members who had been interned in enemy territory had their hospital bills there partly paid, through an extension of benefits-wherever-you-go plans which are beginning to make headway among the associations.

Recently started is something new, medical insurance, particularly for physicians and surgeons' services in the hospitals. This movement is directly sponsored by the medical profession, but is closely coördinated with the Blue Cross. There are 14 of these medical plans in 11 States and one in Puerto Rico.

The medical plans are proceeding cautiously, sometimes having had to reorganize because there was at the start no reliable information either about costs or even what the American people would want.

The Blue Cross and the medical plans are an answer of hospital trustees and administrators, also of the medical profession, to political moves for State medicine. Many of the facts on which arguments for either system will rely are likely to come from these two experiments.—Howard W. B. Blakeslee in San Francisco *Chronicle*

American Hospital Association Plans Survey of Hospitals

Dr. A. C. Bachmeyer, director of the University of Chicago Clinics, was appointed to conduct a two-year survey of America's hospital system at the initial meeting of the Commission on Hospital Care in Philadelphia August 1. The Commission was organized on the request of members of the American Hospital Association for an independent, unbiased study to serve as a basis for plans for future hospital facilities and the extension of those already in service.

In his capacity as permanent director of study, Dr. Bachmeyer will make a survey of hospital facilities in three states—California, Michigan, and one in the South—to determine the health needs of every segment of the population, and to investigate the potentialities for an even wider distribution of hospital service.

On the basis of these studies, a nation-wide plan looking toward greater co-ordination among hospitals will be developed, aimed at extending hospital care of the sick and injured equally to all—the farmer, the laborer, the urban dweller, and those groups requiring specialized attention for mental and incurable diseases.

Dr. Thomas S. Gates, president of the University of Pennsylvania, is chairman of the Commission, which has been financed by a fund of $105,000 contributed by the Kellogg Foundation, the Commonwealth Fund of New York, and the National Foundation for Infantile Paralysis.

The Commission is composed of farm leaders, industrial and labor representatives, and members of the medical and nursing professions.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (39)

Alameda County (1)

Picard, William J., *Berkeley*

Kern County (4)

Buss, William C., *Bakersfield*
Coker, John K., *Bakersfield*
Harris, Squire O., *Bakersfield*
Maschmeyer, Joseph, *Bakersfield*

Los Angeles County (17)

Aaronson, Myer William, *Beverly Hills*
Bach, Walter L., *Palos Verdes*
Bogue, Willis J., *Monrovia*
Brower, Arthur Benedict, *Los Angeles*
Crutcher, Roberta, *Los Angeles*
Dispensa, Johnette G., *Los Angeles*
Joesting, Harold Carl, *Los Angeles*
Linton, William Elmus, *Los Angeles*
Musser, Fred C., *Los Angeles*
Nielsen, Robert F., *Santa Monica*
Oslund, Robert M., *Los Angeles*
Shapero, Edith, *Beverly Hills*
Spomer, Isaac, *San Pedro*
Walker, Sydney, *Northridge*
Warne, Ralph Caldwell, *Los Angeles*
Weisman, Samuel, *Los Angeles*
Wical, Alfred Leslie, *Alhambra*

Orange County (3)

Newton, Raymond A., *Laguna Beach*

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† For roster of officers of component county medical societies, see page 4 in front advertising section.

Specht, Oswald S., *Garden Grove*
Taylor, Irwin E., *Buena Park*

San Bernardino County (1)

Crites, A. H., *Barstow*

San Francisco County (10)

Charlier, Joseph G., *Burbank*
Engel, Samuel, *San Francisco*
Gray, Claude Cleveland, *San Francisco*
Guilfoil, James A., *San Francisco*
Halpern, Lena, *San Francisco*
Moffitt, Herbert C., Jr., *San Francisco*
Popov, Nicholas Paul, *De Ridder, Louisiana*
Sherman, George Fairchild, *San Francisco*
Siris, Evelyn Lillian, *San Francisco*
von Saltza, John W. H., *San Francisco*

Solano County (2)

Fraser, Donald A., *Vallejo*
Watson, George A., *Vallejo*

Sonoma County (1)

Testa, Dumas J., *Healdsburg*

Transfers (3)

Gries, Louis, from Los Angeles County to Solano County.
MacPherson, Douglas G., from San Francisco County to Los Angeles County.
Petty, Louise E., from Mendocino-Lake County to Alameda County.

In Memoriam

Black, Howard. Died at Palo Alto, September 21, 1944, age 70. Graduate of the Starling Medical College, Columbus, Ohio, 1896. Licensed in California in 1900. Doctor Black was a member of the Santa Clara County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Connell, James Albert. Died at Riverside, September 24, 1944, age 65. Graduate of Northwestern University Medical School, Chicago, 1904. Licensed in California in 1920. Doctor Connell was a member of the Riverside County Medical Society, the California Medical Association, and the American Medical Association.

◆

Dunsmoor, Robert Morris. Died at Fontana, November 7, 1944, age 62. Graduate of the College of Physicians and Surgeons, Los Angeles, 1913 Licensed in California in 1913. Doctor Dunsmoor was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Hayton, Charles Henry. Died at Eagle Rock, October 9, 1944, age 75. Graduate of the George Washington University School of Medicine, Washington, D. C., 1911. Licensed in California in 1925. Doctor Hayton was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Johnson, Dwight David. Died at Grass Valley, October 30, 1944, age 85. Graduate of the New York University Medical College, New York, 1883. Licensed in California in 1893. Doctor Johnson was a Retired member of the Placer-Nevada-Sierra County Medical Society, and the California Medical Association.

◆

Jones, Carl Power. Died at Grass Valley, October 18, 1944, age 66. Graduate of the Cooper Medical College, San Francisco, 1907. Licensed in California in 1908. Doctor Jones was a member of the Placer-Nevada-Sierra County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Lennon, Thomas Joseph. (Major) United States Army Medical Corps. Died at Hammond General Hospital, Modesto, November 13, 1944, age 48. Graduate of the University of California Medical School, Berkeley-San Francisco, 1924. Licensed in California in 1924. Doctor Lennon was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Martin, George Scott. Died at Susanville, October 8, 1944, age 58. Graduate of the University of Louisville School of Medicine, Kentucky, 1909. Licensed in California in 1920. Doctor Martin was a member of the Lassen-Plumas-Modoc County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Meininger, Leo Louis. Died at Palo Alto, October 9, 1944, age 74. Graduate of the Cooper Medical College, San Francisco, 1898. Licensed in California in 1898. Doctor Meininger was a Retired member of the San Francisco County Medical Society, and the California Medical Association.

◆

Nolan, Oscar Frederick. (Lieutenant Colonel) United States Army Medical Corps. Died at Inverness, November 12, 1944, age 44. Graduate of Baylor University, College of Medicine, Dallas, Texas, 1927. Licensed in California in 1928. Doctor Nolan was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Obando, Arcadio Tigrio. Died at Los Angeles, November 5, 1944, age 42. Graduate of Cornell University Medical College, New York, 1930. Licensed in California in 1930. Doctor Obando was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

◆

Pallette, Edward M. Died at Chicago, Illinois, November 16, 1944, age 70. Graduate of the University of Southern California School of Medicine, Los Angeles, 1898. Licensed in California in 1899. Doctor Pallette was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

◆

Pettit, Albert Victor. Died at San Francisco, November 19, 1944, age 53. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1919. Licensed in California in 1919. Doctor Pettit was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

◆

Pidcock, Jeddiah William. Died at Los Angeles, October, 1944, age 67. Graduate of the College of Physicians and Surgeons, San Francisco, 1907. Licensed in California in 1924. Doctor Pidcock was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Ryerson, Scott. Died at New York City, September 17, age 35. Graduate of the University of Buffalo School of Medicine, 1931. Licensed in California in 1933. Doctor Ryerson was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Stewart, Harry James. Died at San Diego, October 31, 1944, age 76. Graduate of Northwestern University Medical School, Chicago, 1893. Licensed in California in 1927. Doctor Stewart was a member of the San Diego County Medical Society, the California Medical Association, and the American Medical Association.

✣

Tullar, Arthur Gilman. Died at North Hollywood, October 11, 1944, age 67. Graduate of Northwestern University Medical School, Chicago, 1906. Licensed in California in 1927. Doctor Tullar was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Correction. In the In Memoriam column of the November issue of CALIFORNIA AND WESTERN MEDICINE, on page 266, the Executive Secretary's clerk who has charge of listings of deceased members of the California Medical Association, inserted the name of William E. Waddell. This was an error. Dr. William E. Waddell of Los Angeles is still active in professional work.

OBITUARIES

Edward Marshall Pallette

1874—1944

Doctor Edward Marshall Pallette has left us. Death came to him quietly on the morning of November 16, in Chicago, where he had gone to attend a meeting of the Board of Trustees of the American Medical Association.

Following the shock of the news of his passing comes the understanding of the truth that Doctor Pallette has not really gone; more than just the memory of him remains—far more. His work, his never failing interest in the profession of medicine, his life of service to mankind, his kindliness, his untiring devotion to duties that imposed many activities—all these have left their imprint upon us—imprints that never will be erased. He remains with us.

Dr. Pallette was born in Wichita, Kan., Jan. 13, 1874. He received the Ph.B. degree from Northwestern University in 1894 and the Ph.M. in 1895. During 1894 he did investigation in the field of biology as the Oliver Marcy Scholar of Northwestern University at the Marine Biological Laboratory, Woods Hole, Mass. He received the degree of doctor of medicine from the College of Medicine of the University of Southern California in 1898 and then did graduate study in the New York Polyclinic in 1901 and in London, Vienna and Berlin at various times thereafter. He was assistant instructor of zoology at Northwestern University in 1894 and 1895, instructor in biology in the Los Angeles High School from 1896 to 1898 and at the same time instructor in histology and embryology in the College of Medicine of the University of Southern California. Following his graduation in medicine he began medical practice in Los Angeles, giving special attention to gynecology. He was associated with the health department of Los Angeles as assistant health officer from 1898 to 1899 and as a member of the Los Angeles County Board of Health from 1905 to 1906. He taught physiology in the College of Dentistry of the University of Southern California from 1900 to 1912 and was a lecturer in obstetrics and gynecology in the Training School for Nurses of St. Vincent's Hospital.

As a distinguished citizen of the State of California he held many special appointments, including examiner for the California State Lunacy Commission from 1905 to 1915, membership on the California State Board of Public Health from 1932 to 1940 and member of the Retirement Board of the Los Angeles City Schools from 1938 to 1939. Since 1938 he had served also as treasurer and member of the Board of Directors of the Blue Cross Plan known as the Hospital Service of Southern California.

During World I, Dr. Pallette served as a captain in the medical corps, acting as surgeon in the Letterman General Hospital at the Presidio in San Francisco and also at Camp Crane in Allentown, Pa. In the present war, since June 1, 1942, he acted as chairman of the Procurement and Assignment Service for Physicians of the War Manpower Commission in Southern California. His interest in general education was exemplified by his membership on the Medical School Advisory Committee of the University of Southern California and the presidency of the Los Angeles County Board of Education.

In the work of the American Medical Association, Dr. Pallette gave also fully of himself for the advancement of the medical profession. He was a member of the House of Delegates in 1933, 1935, 1936 and for the period 1938-1942. In 1942, he was elected a member of the Board of Trustees of the American Medical Association. He was a member of the California State Medical Association and its president in 1936-1937. He was also a former president of the Los Angeles County Medical Association. His membership in special societies included fellowship in the American College of Surgeons, membership in the Los Angeles Surgical Society, the Los Angeles Obstetrical and Gynecological Society, the Los Angeles Academy of Medicine, the Hollywood Academy of Medicine, the Institute of American Genealogy and the American Association for the Advancement of

Science. Of many of these groups he had been president.

In the death of Dr. Pallette, the American Medical Association lost a loyal and distinguished counselor, a self-sacrificing and devoted member of its Board of Trustees.

Surviving Doctor Pallette are Mrs. Elizabeth Brown Pallette; three sons, Lt. Col. Edward C. Pallette, Warren S. Pallette and Drew B. Pallette; and a daughter, Elizabeth D. Pallette.

Funeral services were held Wednesday morning, November 22, at St. Paul's Cathedral, Los Angeles.

Active pall bearers were: Messrs. Owen Brower, Earl Kennick, Andrew Brown, Lawrence Hall, Oscar Trippet and Dr. John Martin Askey.

Honorary pall bearers were: Drs. C. G. Toland, Wm. H. Kiger, Edwin O. Palmer, Egerton L. Crispin, B. O. Raulston, James F. Percy, E. Vincent Askey, George Denhart, C. W. Bonynge, Rufus B. von KleinSmid, Oscar Lawler, Frank Barham, A. J. Scholl, Thomas Chalmers Myers, Francis L. Anton, Roy W. Hammack, Lowell S. Goin, L. A. Alesen, E. T. Remmen, Wayland Morrison, John B. Doyle, William R. Molony, Arthur S. Granger, William H. Daniel, Charles T. Sturgeon, Maurice Kahn and Edward F. Schewe; and Messrs. Howard Burrell, Nathan Newby, Sr., Barry Hillard, Paul Mattoon, Dwight L. Clarke, Colin Gair, Cassius M. Jay, Ritz E. Heerman, and S. K. Cochems.*

Carl Power Jones

1878—1944

Dr. Carl Power Jones was born in Grass Valley—the son of Dr. and Mrs. W. C. Jones. Since 1875, a period of almost seventy years, the family of Dr. Carl Power Jones has furnished outstanding members of the Medical Profession of Nevada County. His death closes this long term of medical service begun by his father, the late Dr. W. C. Jones, and carried on by Carl and his brothers, the late William and John Jones.

Following his graduation from Cooper Medical College Carl Jones interned at St. Lukes and at the old City and County Hospital. Since 1907, when he opened his office, in partnership with his brother John, Dr. Carl had practiced continuously in Grass Valley, except for a period of service as Lieutenant-Commander in the United States Navy in 1917-18. He had been an honored member of the Placer-Nevada-Sierra County Medical Society for thirty-seven years—one of the oldest members in point of years of service.

Carl Jones was one of the outstanding surgeons of Northern California—an ethical practitioner, who gave liberally of his time, his talents and his resources for the promotion of the health of the community and for the betterment of the health of his patients. A brief article concerning Grass Valley $700,000 Postwar Hospital, of which Dr. Jones was the indirect sponsor, appeared in CALIFORNIA AND WESTERN MEDICINE, for September, on page 174.

Carl Jones was a man of many and varied interests. He was an enthusiastic sportsman, interested in fine horses and in aviation, a gold-mining owner and promoter, with an abiding faith in the mining future of the Grass Valley District, and an earnest worker in every movement for the improvement of his City and County. But, first and foremost, he was a capable and honest practitioner of the healing art in which he was extraordinarily successful.

Carl Jones liked people and people liked Carl Jones. His sudden death on October 18, 1944, removed from Grass Valley and from Nevada County a beloved figure who was the friend, counsellor and physician of members of three generations, to whom his passing assumed the proportions of a calamity.

George Scott Martin

1885—1944

George Scott Martin died at his home in Susanville, California, on Sunday, October 8, 1944, of coronary occlusion, at the age of 58. He was a native of Dallas, Texas. Graduated in 1909 from the University of Louisville Medical School, Louisville, Kentucky. He was first honor student all four years, and served his internship in the Louisville City Hospital. Later he practiced medicine in Dallas, Texas, and Phoenix, Arizona. In World War I, Dr. Martin served in France and England with the rank of Major. He located in Susanville, California, in 1920, where he built Riverside Hospital, which he owned until August, 1944.

Dr. Martin was Past Master Blue Lodge in Arizona; 32nd degree Mason; held prominent posts in Masonic bodies. Was a member of the American Association of Industrial Physicians and Surgeons; City Health Officer of Susanville, and Physician and Surgeon for the Southern Pacific Railroad in Susanville.

U. S. Casualties Near Half Million

Washington, Nov. 2.—American casualties in excess of half a million for the first three years of the war were indicated today in official Army and Navy statements.

Casualties to date include more than 110,000 dead, and approximately 260,000 wounded, 67,000 missing and 58,000 prisoners of war.

The nineteen months of World War I cost the United States about 318,000 casualties, including about 50,000 killed.

In the two years and eleven months of the present war, United States Army dead alone totaled more than 80,000, and in addition, nearly 30,000 members of the naval service and merchant marine have been killed.

Army casualties in all theaters now total more than 420 000.

These include 417,121 casualties reported to the War Department up to October 21, and 3,221 casualties sustained in the invasion of the Philippines up to October 31.

The *War Department's* totals as of October 21 are as follows:

Killed, 80,666; wounded, 229,212; missing, 53,622; prisoners of war, 53,621. Of the wounded, 105,449 have returned to duty.

Casualties in the Leyte operation, as announced by Gen. Douglas MacArthur, included 706 killed, 270 missing, and 2,245 wounded.

The War Department figures, of course, do not include casualties suffered in France, Italy or elsewhere since October 21.

Of the 81,000 American soldiers killed thus far in the war, approximately 50,000 gave their lives in the European phases of the war, including the north African invasion, and the Italian and French campaigns.

Approximately 30 000 Americans have been killed in France, 17,000 in Italy, and 2,500 were killed in North Africa and Tunisia. The remaining 31,000 have been killed in various Pacific campaigns.

The *Navy Department* tonight announced that casualties in the naval service so far notified to next of kin total 70,571, including 28,231 killed, 28,441 wounded, 9,421 missing, and 4,478 prisoners of war. These figures do not include naval casualties sustained in the last week's sea-air battle of the Philippines.

Diokles of Carystos (*ca.* 300 B. C.) wrote the first book on anatomy describing the lungs, heart, gallbladder, ileocecal valve, ureters, ovaries and tubes. He discovered the *"Punctum Saliens."*

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* For editorial comment, see page 279.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Session will convene in Los Angeles. Dates of the seventy-fourth annual session, to be held in 1945: Sunday, Monday, May 6-7.

American Medical Association. The 1945 Session will be held in Philadelphia, June 18-22, 1945. (*J.A.M.A.*, Nov. 25, 1944, p. 843.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*
2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*
3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*
4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*
5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*
6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*
7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*
8. *Expansion of public health and medical services consistent with the American system of democracy.*

(Note: For interpretative comments, see *J.A.M.A.*, June 24, 1944, pp. 574-576.)

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays:

KFAC presents the Saturday programs at 10:15 a. m., under the title, "Your Doctor and You."

In December, KFAC will present these broadcasts on the following Saturdays: December 2, 9, 16, 23, and 30.

The Saturday broadcasts of KFI are given at 9:45 a. m., under the title, "The Road to Health."

"Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association is on the air each Saturday at 1:30 p.m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Interesting and Amusing:* Be sure to read G. W. Corner's *Ourselves Unborn: An Embryologist's Essay on Man* (Yale Press, New Haven, Conn., 1944, $3), the best Terry Lecture in years, wise, witty and well-done. Enjoy A. E. Hertzler's *Ventures in Science of a Country Surgeon* (privately printed, Halstead, Kansas, 1944), clear, colorful and courageous, with Ray Allen's foreword stressing Hertzler's thesis that the good doctor is a student always. Get R. M. Wilson's *British Medicine* (Britain in Pictures series, Hastings House, N. Y., 1944, $1.25) if for nothing else than its fine illustrations. Note National Music Council (338 W. 89th St., N. Y. 24) reports on use of music in hospitals for mental and nervous diseases.

2. *To Think About:* Excellent recommendations for the *National Medical Library* in survey of Army Medical Library by K. D. Metcalf & Co. (Am. Lib. Asso., Chicago, 1944). Q. Wright's homily on freedom in universities (*A.A.U.P. Bull.*, 30:167, 1944), neglects to mention significance of personal responsibility in justifying freedom. H. T. Houf discusses the ideal University president, noting importance of unselfishness (ibid., p. 277). J. K. Wright reports on human nature in science (*Science*, 100:299, Oct. 6, 1944). Nursing Information Bureau of American Nurses' Asso. issues *Facts About Nursing*, 1944 (1790 Broadway, N. Y. 19). Better write for a copy!

3. *Books to Get:* Edwards Bros., Ann Arbor, Mich., will issue the S. C. Brooks' long awaited monograph on permeability, about which they had such trouble abroad and at home. Also from Edwards Bros.: H. Buscher on pathology and therapy of chemical warfare injuries ($4); C. A. O. Franz on military surgery ($13); K. Hinsberg's Geschwulstproblem in Chemie and Physiologie ($8.25), and F. Kauffmann on the bacteriology of the salmonella organisms ($7). For popular use it's hard to beat E. W. Hayes' *Tuberculosis As It Comes and Goes* (privately printed, Monrovia, Calif., 1943). G. Hosford recommends S. A. Fox's *Your Eyes* (Knopf, N. Y., 1944, $3). Genial Manchester historian (medical), E. M. Brockbank offers neat biography of John Dalton and account of his theory of colour vision (Manchester Univ. Press, 1944, $2). R. A. Moore writes a new *Pathology* (Saunders, Phila., 1944). A. R. Rich's *Pathogenesis of Tuberculosis* looks like a honey (C. C. Thomas, Springfield, Ill., 1944, $10.50). E. F. Burton offers *The Electron Microscope* (Reinhold, N. Y., 1944, $3.85). Harvey Cushing's Visit to *Le Puy-en-Velay* appears with notes by John Fulton (Rowfant Club, Cleveland 15, $8). Get R. J. Behan's *Pain: Its Origin, Conduction, Perception and Diagnos-Significance* (Appleton, N. Y., 1944). Important is W. R. Bloor's *Biochemistry of the Fatty Acids* (Reinhold, N. Y., 1944, $6). R. A. Sawyer's *Experimental Spectroscopy* looks tops (Prentice-Hall, N. Y., 1944, $3.75). W. W. Babcock offers *Principles and Practice of Surgery* (Lea & Febiger, Phila., 1944, $12). R. S. Harris and K. V. Thimann survey *Vitamins and Hor-*

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† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

mones (Academic Press, N. Y., 1944, $6.80). G. Seifer's *Virus Diseases in Man, Animal and Plant* is O.K. (Philosophical Lib., N. Y., 1944, $5). Interesting is W. F. Norwood's *Medical Education in the U. S. Before the Civil War* (Univ. Penn. Press, Phila., 1944, $6). Outstanding is S. Bunnell's *Surgery of the Hand* (Lippincott, Phila., 1944, $12). See F. D. Murphy's *Acute Medical Disorders* (Davis, Phila., 1944, $6). J. Dollard & Co. (Yale) study *Frustration and Aggression* (Kegan Paul, Lond., 1944, $3). L. R. Broster undertakes *A Study in the Surgery of Sex* (Heineman, Lond., 1944, $5).

4. *Antibiotics:* E. S. Duthie describes production of penicillinase by organisms of subtilis group (*Brit. J. Exp. Path.*, 25:96, 1944). G. Soo Hoo and R. J. Schnitzer note that penicillin synergizes with sulfonamides but not with acridines (*Arch. Biochem.*, 5:99, 1944). M. R. Lewis observes that while impure penicillin may damage sarcomatous cells, pure penicillin will not (*Science*, 100:314, Oct. 6, 1944). A. E. Francis and Co. find definitely that patulin has no value in common cold (*Lancet*, 2:370, Sept. 16, 1944). J. W. Bigger notes that penicillin is inactivated by blood and serum (*Lancet*, 2:400, Sept. 24, 1944). C. J. Cavallito and J. H. Bailey report that cysteine and esters, but not other SH cmpds, inactivate penicillin, citrinin, clavacin, pyocyanine, and new antibiotic from allium sativum (*Science*, 100, 390, Oct. 27, 1944). Note on same page G. Schwartzman's cellophane method for growing penicillin.

Stanford President Talks to A.A.M.C.—The major problem facing medical education today is a reconsideration of the entire teaching program to determine what to eliminate and what to add, Donald B. Tresidder, M.D., president of Stanford University, declared on October 24, at a meeting in Detroit of the American Association of Medical Colleges.

Stressing the fact that an accelerated teaching program now in operation is inevitable in wartime to meet a critical shortage of doctors, Dr. Tresidder suggested that the important issue to consider is "an analysis of the degree of competence we want developed in the medical profession, and the means of developing it."

A total of $34,000 in War Bonds as prizes for the best art works by physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty" (in war and in peace) has been announced.

This prize contest is open to any physician member of the American Physicians Art Association, including medical officers in the Armed Forces of the United States and Canada.

Full information available on request of the sponsor, Mead Johnson & Co., Evansville, Ind., U.S.A.

Doctors Term Carrying Baby 18 Years Rarity.—Southern California medical circles last month buzzed with discussion of the disclosure that Mrs. Martin Buck, 56, a visitor in Valyermo in the South Antelope Valley, had carried an unborn baby for 18 years.

"Rarer than quadruplets," "once in a million," "extremely unusual" ran the comments on how Dr. H. H. Snook had performed the operation in his Palmdale Hospital.

Learning of the primary abdominal pregnancy in which an operation similar to a Caesarean section was used to remove the mummified body of the baby, Dr. Burrell O. Raulston, dean of the University of Southern California School of Medicine, said, "It is one of the rarest complications that accompany pregnancy and childbirth."

Dr. Raulston said obstetricians on the S. C. faculty reported such an instance occurs perhaps once in a million times.

Dr. Walter E. Macpherson, president of the College of Medical Evangelists, said this institution is especially curious about the strange case because Dr. Snook is one of its graduates.

Although Mrs. Buck first felt apparent labor pains after carrying the child for eight months in her home at Bonnerdale, Ark., she dismissed the symptoms as a tumor when no baby appeared. Not until last month, when she first called on Dr. Snook to treat a severe cold, were x-rays used to discover the amazing rarity.

Dr. Macpherson said his associates found, in a possibly incomplete search, only five authentic reported cases of similar character. Two such extra-uterine cases lasted for 46 years each, one 23 years and one 10 years.

"About one of every 4,800 of these ectopic embryos is normal at all and only one of every 480,000 lives to any length of time within the body of the mother," the medical college president said.

"For rarity, this may be compared with quadruplets, which occur only once in every 400,000 births."—Los Angeles *Times*, November 30.

Honors to Dr. J. C. Geiger, Director of Public Health, City and County of San Francisco.—On August 23, 1944, the Faculty of Medicine, the University Senate and the Board of Administrators of Tulane University of Louisiana, requested Dr. J. C. Geiger to make the Commencement address at its largest Commencement ever to be held, on October 14, 1944, in New Orleans, Louisiana.

At that time the honorary degree of Doctor of Science was conferred upon him, this being the second honorary degree to be so received from this University. The current citation is as follows: "A noted epidemiologist, a medical officer of health and author of excellence, and Tulane's most distinguished alumnus."

American College of Radiology.—Lt. Comdr. L. Henry Garland (MC), U.S.N.R., formerly of San Francisco, now stationed at the U. S. Naval Hospital, Astoria, Oregon, has been elected a member of the American Board of Radiology, according to a recent announcement by the Radiological Society of North America. Doctor Garland was elected to the examining board by the Radiological Society to serve as one of its representatives for a six-year term.

Military Order of the World Wars.—Cornelius O. Bailey, M. D., Major, U. S. Army, Medical Corps, World War I, has been notified of his reëlection as Surgeon General of the Military Order of the World Wars, at their National Convention, held in September, at Atlanta, Georgia.

Thomas Carlyle (1795-1881).—The physical armor of Carlyle was invulnerable to serious illness, but the hardships of his youth left him a chronic dyspeptic. His sufferings undoubtedly were real enough, yet his imagination, aided by the result of self-medication with copious quantities of castor oil, magnified his troubles a hundredfold. Extremely exacting, and often carping in his views of men and events, Carlyle has been held up as another example of genius and bad digestion going hand in hand. —Warner's *Calendar of Medical History.*

Cold Vaccines of Doubtful Value.—Vaccines popularly supposed to prevent or cure the common cold were condemned on November 30 as having no proved value.

The joint report by the A.M.A. Councils on Pharmacy and Chemistry, and Industrial Health, included vaccines administered hypodermically, by swallowing capsules (oral vaccine), and by local spraying of the upper respiratory tract.

"Decisive evidence of the value of any vaccine is not forthcoming, and the weight of careful studies clearly indicates that none of the vaccines now available when administered by the routes advised have proved of value," the report said.

"Vaccines for colds can not be recommended for routine administration to industrial groups or to individuals."

Correction.—In the In Memoriam column of the November issue of CALIFORNIA AND WESTERN MEDICINE, on page 266, the Executive Secretary's clerk who has charge of listings of deceased members of the California Medical Association, inserted the name of William E. Waddell. This was an error. Dr. William E. Waddell of Los Angeles is still active in professional work.

Medical Test for All Argentine Citizens.—A new government decree requiring periodic medical examination for all Argentines was announced by the Argentine Government on December 3.

Wisconsin Vitamin Patents Held Invalid by U. S. Court.—The valuable Steenbock patents for food irradiation, held by the Wisconsin Alumni Research Foundation, were for the second time held invalid on November 24 by the Ninth Federal Circuit Court of Appeals. Winner by the decision is Vitamin Technologists, Inc., a Los Angeles concern.

This time the court described the patent—which has been netting the Wisconsin Foundation nearly a million dollars a year for scientific research—as a "profit-controlled monopoly barrier." . . .

Judge William Denman, who wrote this opinion, said: "The evidence and appellee's brief are replete with well-verified statements of the great boon to humanity of Dr. Steenbock's scientific discoveries for the prevention and cure of rickets. The truth of such statements make stronger the contention that it is a public offense to withhold such processes from any of the principal foods of the rachitic poor."

The court did not invalidate the patent on the ground of public interest, however, but mainly on the premise that the principle of improving certain food substances by exposing them to ultraviolet rays, from sun or lamp, was not a new one.

New Hospital at Lynwood in Los Angeles County.—Construction of the new $600,000 St. Francis Hospital at Imperial and Century Boulevards started on November 21, according to Rt. Rev. Msgr. Thomas J. O'Dwyer, director of the Catholic Charities, sponsors of the project.

No definite completion date has been set, but it is hoped by Msgr. O'Dwyer that formal dedication services can be held on or before July 1.

The initial structure will provide for 100 beds, but construction of a maternity wing and facilities for additional general wards are already contemplated.

It is pointed out by Msgr. O'Dwyer that at least 500 more hospital beds are needed in this area to bring it up to the national average. Acuteness of the local hospital situation, he said, prompted Congress to appropriate $400,000 of Lanham Act funds for the structure. An additional $200,000 for fixtures, equipment and furnishings is being raised here and in surrounding communities by public subscription.

The new hospital will be equipped with the latest clinical laboratory and surgical innovations and its facilities will be available to all, regardless of race or creed.

California 1950 Population May Be Second Largest.—California is looking forward to the privileges—and headaches—connected with becoming the State with the second largest population in the country.

Governor Warren has put it this way:

"California has passed Ohio and Illinois to rank third among States in population. With the postwar industrial and construction program now being formulated, we should overcome Pennsylvania's lead of about 1,000,000 by 1950."

Colonel Alexander Heron, state director of reconstruction and reëmployment, also looking six years ahead, says:

"California will retain all but one-fourth or one-fifth of its wartime migrants and will have a population of 8,500,000 to 9,000 000 by 1950."

A general study of the population status, supervised by Colonel Heron, says:

"Between April, 1940, and January, 1944, the war transformed our State. In that three and a half year period, California acquired factories and plants turning out untold quantities of war materials, was crossed and recrossed by countless transient military and civilian personnel on urgent war business, served as a jumping off place for men and materials for one of the great war efforts, and harbored military installations of unprecedented magnitude.

"In the process, the State acquired an extra million and a half people who had not lived here before, a jump from slightly under 7,000,000 to almost 8,500 000. Of these, 1,320 000 were migrants from other States who came to work in the war industries or for other reasons moved to California. The rest were babies born here.

"The two increases, 'natural' increase and increase by migration, broke a number of records. They constituted the greatest numerical increase of any State for the same period. California by-passed Ohio and Illinois to become the third most populous state in the union, exceeded only by New York and Pennsylvania. And in the single year 1943 the rate of population growth—600 000 per year—was the most phenomenal ever recorded by any one of the United States."

Doctors Assert Vitamin Tests Prove Negative.—Physicians who conducted a 30-day vitamin-feeding experiment with 200 persons, at the Army's request, on November 23 reported the "administration of vitamin supplements to a group of apparently normal persons, consuming the usual American diet, had no demonstrable beneficial effect."

The study was made at Duke University School of Medicine at the request of the quartermaster general's office.

The authors, Dr. Julian M. Ruffin and Dr. David Cayer of Durham, N. C., said:

"At present the use of vitamins is widespread throughout the country, not only in the treatment of disease, but also by apparently normal persons.

"While no one would question the employment of vitamin therapy in frank deficiency disease, or even in suspected deficiency states, still one wonders if the indiscriminate use of vitamins, sold over the counter to people who have no obvious disease, is justified.

"It has been implied that, even when no demonstrable deficiency exists, one's sense of well being and ability to perform work can be improved greatly by the addition of vitamins to the diet.

"As pointed out by the Council on Food and Nutrition and on Industrial Health (of the American Medical Association) there is at present no conclusive evidence to substantiate this point of view."

Cadet Nurse Residence Dedication Rites Held.—The new U. S. Cadet Nurse Corps residence at the California Hospital School of Nursing, in Los Angeles, was dedicated on October 29, with F. C. Noel, president of the board of directors, accepting Moore Hall as the new home of trainee nurses.

The residence is named in honor of the late Dr. E. C. Moore, who was connected with the California Hospital many years before his death last July.

The building was acquired under the Federal Works Agency and was presented to Noel by Wright L. Felt, regional engineer of the Federal Works Agency.

Bicknell Building of California Hospital in Los Angeles to Be Opened Soon.—Remodeling of the Bicknell Building, which will provide an additional 110 beds for patients, as an annex to the main building of the California Hospital, is rapidly nearing completion. This project is a Federal Works Agency Grant-in-aid program in line with the government's campaign to utilize existing facilities in an effort to increase the number of hospital beds in Los Angeles area, where an acute shortage exists.

An additional 120 employees will be needed to adequately staff departments which will be affected by the increased patient load. The War Manpower Commission has provided the hospital with a special manpower priority and a recruitment program is now in progress. An additional 24 graduate nurses and 24 nurse attendants will be required to provide bedside care for the patients when the new unit is filled to capacity. Special emphasis is being placed upon this phase of the recruitment program, due to the present shortage of nurses in this area.

The building has been equipped with new furniture and modern facilities. The unit will consist largely of ward accommodations.

The new addition will give the California Hospital a total capacity of 411 adult beds and 48 bassinets.

Robert A. Peers in Practice for 45 Years.—Recently Doctor Robert A. Peers, Medical Director of the Colfax School for the Tuberculous, completed his 45th year of practice in Colfax in Auburn County. His many friends took occasion to send him congratulations. Doctor Peers was president of the California Medical Association in 1935.

Governor Warren Urges State Control of All Hospitals.—Gov. Warren on November 27 requested Dr. Wilton L. Halverson, director of public health, to draft legislation which, if enacted, would place all hospitals in the State under control of a State agency.

Dr. Halverson reported that "it is easy to start up a hospital now because there are no State licensing laws," and said that as a result "some institutions are not giving good service."

"Probably some deaths have occurred which could have been prevented by proper care," Dr. Halverson said.

Dr. Halverson and Charles M. Wollenberg, director of social welfare, told the Governor's council meeting that they had agreed jurisdiction over county hospitals, now under the Welfare Department, should be transferred to the Health Department.

Director Wollenberg said surveys made by members of his staff showed "most county hospitals are not good."

Diploma Mills of California.—For many years, in California, all that was necessary to secure incorporation papers for institutions of learning having authority to grant degrees, was to make application to the Secretary of State, in much the same manner in which a business group incorporates.

It was during those years that a considerable number of fly-by-night educational institutions came into existence. Subsequently a law was enacted requiring evidence of material and other resources before incorporation of an institution of learning, having power to grant degrees, could be granted. In connection with the above, the *J.A.M.A.* for November 4, 1944, on page 648, prints an item, "Another Diploma Mill," in which are mentioned the following institutions: "White Cross Medical College of the University of Physicians and Surgeons of Southern California"; "Extension Branch of the Los Angeles University, College of Psychiatry"; and "Golden State University of Los Angeles."

The item relates that the New York County Grand Jury on October 10th took steps to bring to task a promoter who was using the names of the above institutions.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Sacramento Doctors to Quit License Fight

Sacramento Society for Medical Improvement probably will not carry out its threat to take legal action to prevent the City from levying a license fee on doctors, Dr. Wayne Pollock, president of the society, said on October 30.

He said, however, that attorneys for the organization are still studying the matter.

The new business license ordinance, which went into effect after a petition for a referendum vote failed last week, levies an annual fee of $24 on doctors.

Before it was adopted by the City Council, the Society for Medical Improvement fought the measure on grounds that it was indirectly "a tax on sick people."—Sacramento *Union*, October 31.

New Concession Given British Soldiers Wishing to be Fathers

Cairo, Africa. (U.P.)—The British army committee on compassionate posting—better known as the baby leave committee—made another concession to the thousands of Tommies in the Middle East who are anxious to return home and become fathers after years of service in the desert.

The committee is composed of five officers and five enlisted men, with a lieutenant colonel as chairman. All are anonymous. The chairman recently announced that high priority will be extended to soldiers who could have fathered babies if they had wanted to before the war, but didn't. Previous preference had been given soldiers now medically able to procreate, but who hadn't been before being shipped to the Middle East.

Government authorities here deplored the publicity given the baby leave committee among troops in this theater, resulting in the committee being inundated with applications. There isn't enough shipping space to accommodate the flood of applicants, and they will have to take their turn. . . . —Samuel Souki in Los Angeles *Times*.

U. of Texas President Is Discharged

Houston, Texas, Nov. 1 (UP.)—Dr. Homer P. Rainey, president of the University of Texas, has been discharged and three members of the Board of Regents have resigned, it was announced tonight after the regents ended a closed session at the Rice Hotel here.

Announcement of the discharge of President Rainey was made by Leo P. Haynes, secretary of the board. (Note. For other items, see in CALIFORNIA AND WESTERN MEDICINE, for November, on page 269.)—San Francisco *Chronicle*, November 2.

San Francisco Health Director Honored

Dr. Geiger Addresses Tulane Graduates

San Francisco and its Department of Public Health won acclaim yesterday when Dr. J. C. Geiger, City Health Director, presented the commencement address at Tulane University of Louisiana at New Orleans.

Not only was Dr. Geiger honored as the main speaker of the day, but he also had the honorary degree of Doctor of Science conferred upon him—his second honorary degree from Tulane. In his career as city health officer of San Francisco he has received seven honorary degrees from various universities.

Dr. Geiger was given the degree with the citation: "A noted epidemiologist, a medical officer of health and author of excellence, and Tulane's most distinguished alumnus."

For his study and research on the subject of epidemics and the control of disease in crowded areas, Dr. Geiger—according to faculty members of the institution—has been placed among a galaxy of notable medical men of the Southern States.

A special reception for the city health officer and Mrs. Geiger was held on the Tulane campus Friday, followed by a ceremony in which a graduate student was awarded the Geiger medal—a scholarship award which was established many years ago by the earlier members of the doctor's family.

The medal and scholarship are awarded each year to a graduate student winning a degree of Doctor of Philosophy for a thesis of original research work on a public health problem of interest to the Southern States or Central American countries. Many students who have later become famous physicians have received this award and their research works have been published throughout the country.

Dr. Geiger's commencement address was entitled, "The Health Department of the Future—a Discussion of Some Problems."

In his talk Dr. Geiger said he believed the accelerated treatments for gonorrhea and syphilis with sulpha drugs and penicillin had proved "ineffective generally" in many cases, but that progress had been made.

"It is felt that the so-called rapid treatment is only effective in 50 per cent of the cases treated, and that the one-day penicillin gonorrhea treatment is effective in only 70 per cent of the cases," he said.

"The newly devised 10-week treatment for syphilis is relatively safe therapeutically and efficient in the treatment," he added.—San Francisco *Chronicle*, October 15.

MEDICAL JURISPRUDENCE†

Hartley F. Peart, Esq.
San Francisco

Regulation of Medical Staff By Private Hospital

From time to time the question has arisen as to the right of a private hospital to bar a particular physician from the use of its facilities. We will set forth herein the general rules governing the regulation of the staff of a hospital.

The principle is set forth in *30 Corpus Juris* at page *463* that "a hospital may prescribe reasonable rules concerning the qualifications of physicians allowed to practice in the hospital. The governing body of a hospital may refuse to permit physicians professing a certain system of medicine to practice in the hospital, adopt such regulations as are proper or deemed by it necessary or expedient to improve the hospital, . . ." and it is stated in an annotation on this subject in *60 A.L.R.* at page *656:*

> "Although there are comparatively few cases on the subject under annotation, it seems to be the practically unanimous opinion that private hospitals have the right to exclude licensed physicians from the use of the hospital, and that such exclusion rests within the sound discretion of the managing authorities."

It is apparent that the same rule is applied to private hospitals as to membership in associations such as the California Medical Association or the local county medical societies. A private hospital, just as the members of such an association, have a right to govern their internal affairs without interference so long as their actions are reasonable and in accordance with the by-laws, articles of incorporation or other instrument regulating their operation.

There has been, however, considerable litigation over the right of a hospital to exclude a licensed physician from the use of the hospital.

In *Hughes v. Good Samaritan Hospital, et al.* (Ky. January 16, 1942) 158 S.W. (2d) 159, the superintendent of the defendant hospital ruled that it would be necessary for the plaintiff to have the endorsement of the proper board of officers of the American College of Surgeons before he would be permitted to use the surgery room. The plaintiff was a licensed physician who had had a successful practice and apparently his ability as a surgeon was unquestioned. The court found that the underlying reason for denying the use of the operating room to plaintiff was that he had "invaded the field of the specialist" by performing certain operations which are usually performed by specialists. The court held that this private hospital had the right to exclude a licensed physician from the use of the hospital and that such exclusion rested within the discretion of the managing authorities. It was said that the plaintiff had no vested right to practice in the hospital's operating room notwithstanding the fact that he was a competent and qualified surgeon. The opinion rendered quoted with approval from the case of *Van Campen v. Olean General Hospital,* 205 N.Y.S. 554.

In the latter case the defendant hospital was a membership corporation of which the plaintiff, a licensed physician, was a member. For a time he was on the staff of the hospital. Because of "petty" differences between the plaintiff and the members of the staff he was dropped from the staff by action of the board of directors, and the privilege of treating patients in the hospital was refused him. It was held that the court would not interfere with the action of the board of directors as they had a wide discretion in determining the policy of the corporation and, in the absence of fraud or bad faith, the courts will not interfere. It was said "another by-law provides that, if the board of directors shall determine that the character, conduct or acts of any member of the medical staff are such as to interfere with the orderly conduct of the hospital, the board may by resolution remove or suspend him. There is no provision in the by-laws for a hearing prior to removal or suspension. We think none is required. The selection and retention of physicians to treat patients admitted to the hospital are matters of judgment and discipline. The power to appoint usually implies the authority to remove."

In *Harris v. Thomas* (Texas, 1920) 217 S.W. 1068, the defendant hospital appointed a committee to reorganize it and to select members of the staff. The plaintiff, an osteopath, who had practiced for a number of years and used the facilities of the hospital, was not named as a member. The Court in refusing the plaintiff relief said:

> "We believe it to be the right of the sanitarium to refuse business relation with appellant, if it sees proper to do so, and also to adopt such regulations as are proper or deemed by it necessary or expedient to improve its efficiency and standards of service. . ."

One limitation upon the rights of a private hospital is the fact that certain emergency cases must be admitted without regard to the attending physician. This phase of the problem will be considered in the next issue of this column.

Irrigation of the bladder in renal colic, cystitis and gonorrhea was employed with gratifying results by John of Arderne (1306-1390).

Antonio Musa Brassavola, of Ferrara (1500-1555), who was the first of his time to reintroduce tracheotomy, wrote extensively on the subject of syphilis.

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† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVII, No. 12, December, 1919

EXCERPTS FROM EDITORIAL NOTES

The Drug Addict Question.—Recognition of the evils and wide distribution of drug addiction has advanced to the point where we are witnessing various governmental efforts to control the use of habit-forming drugs. That these efforts have not met with adequate success is demonstrated by the problems now appearing of the care and criminality of drug addicts who are hampered under the law in procuring a sufficient supply of the drug to keep them comfortable, law-abiding and productive workers. Illicit drug dealers are profiteering to a huge extent among these unfortunates and thus creating a situation still further operating to cause criminality, suffering and social inefficiency. . . .

Minimum Wage for Office Workers.—The State Industrial Welfare Commission, under date of June 20, 1919, issued an order affecting the minimum wage lawful to be paid women and minors. This is set at $13.50 per week, and includes workers in professional offices. The only exceptions to this rule apply to learners who, under certain conditions, may receive smaller wages. The total proportion of learners to all women employed shall not be greater than 33 1/3 per cent. . . .

Physicians should take due notice of this order and govern themselves accordingly.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Notes on Encephalitis Lethargica in San Francisco," by Philip King Brown, San Francisco.—Encephalitis Lethargica has made its appearance on the Pacific Coast in numbers sufficient to emphasize the epidemic character of the disease, and in a guise that frequently detracts attention from the chief characteristics of the disease as thus far described. . . .

From an Article on "Intestinal Flagellates: A Plea for Their Pathogenicity," by John V. Barrow, S.B., M.D., Los Angeles.—A general survey of the literature on flagellated protozoa impresses one with their growing importance. Twenty years ago, they were reported in different human organs as a sort of curiosity, but scarcely to be thought of as pathogenic parasites. However, very recent years have brought a greater realization of their importance as producers of pathology. The amoeba and ciliated balantidium coli were first to gain recognition. Now they have a young army of medical men ready to respect their pathogenic power. What has happened in the rôle of the amoeba, and balantidium, is beginning to be realized in the case of the flagellated monads . . .

From an Article on "A Plea for the Earlier Recognition of Subacute Infantile Scurvy," by Langley Porter, M.D., M.R.C.S. (Eng.), San Francisco, and W. E. Carter, M.D., Los Angeles.—It is a popular lay notion which unfortunately has found its way into the medical mind

(Continued in Front Advertising Section, on Page 12)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.,
Secretary-Treasurer

News

Board Continues Doctor's Plea

Sacramento (AP.)—The State Board of Medical Examiners last night continued until March action on the application of Nathan S. Housman, former San Francisco physician, for restoration of his medical license.

Housman's license was revoked by the board after he was convicted of keeping improper narcotic records and of perjury in his testimony at the trial.

The board placed on probation for a year Dr. Edward M. Lundegaard, Oakland, who was charged with aiding unlicensed persons in operation of a treatment for alcoholism.—Vallejo *Times Herald,* October 19.

"Opportunity Open to Foreign Physicians: The San Francisco Committee for Service to Émigrés has been informed by the National Committee for Resettlement of Foreign Physicians that the United Nations Relief and Rehabilitation Administration is in need of physicans from all branches of medicine. The age limit is 55 years. United States licensure is not essential. Germans, Hungarians, Bulgarians and Austrians, who are not yet American citizens, are not eligible, although unusually well qualified Austrians may be considered. Nationals of non-Axis countries are eligible. Time spent in the employ of the United Nations Relief and Rehabilitation Administration (UNRRA) overseas will not be deducted from the required period of U. S. residency in computing eligibility for U. S. citizenship. Amercan citizens are, of course, eligible. The salary ranges from $3 200 to $7 000 a year, plus total maintenance on a per diem basis. (Anyone interested may receive further information by telephoning Miss Schoenholz at Fillmore 4513.)" (From *Emanu-El Jewish Journal,* Oct. 6, 1944.)

"Dr. Charles Bacon Boudwin, 64, 8656 East Fourteenth Street, Oakland, and his nurse, Mrs. Ella Berry, 41, today faced prison sentences of two to five years after an Oakland superior court jury yesterday found them guilty of performing an abortion on Mrs. Mildred Hatton of 6425 Essex Street a year ago. Boudwin's license to practice medicine has been withdrawn." (San Francisco *Bulletin,* October 14, 1944.)

"A Coroner's jury in Santa Monica yesterday found that Mrs. Frances Drapier, 33, of 1228 Lincoln Blvd., Santa Monica, died last Saturday as a result of an illegal operation, but the jury did not name any person responsible for the death. Following the inquest, Deputy District Attorney Kenneth Lynch said there was insufficient evidence to file a complaint against Mae Wilson, 53-year-old osteopath, who was arrested Tuesday on suspicion of murder in connection with Mrs. Drapier's death. She was released at that time on $5,000 bail." (Los Angeles *Times,* Oct. 27, 1944.)

"Charged with two violations of the state health and safety code, Dr. Milton F. Novotny, Long Beach physician, yesterday was acquitted in Los Angeles superior

(Continued in Back Advertising Section, on Page 40)

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† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

Historical reminiscences, papers and other archives will be welcomed by the C.M.A. Committee on History, to whom such should be sent. Address same to the Committee's Secretary, Dr. George H. Kress, Room 2004, 450 Sutter, San Francisco, 8.

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 20)

of Los Angeles and the Parent-Teachers' Federation of Los Angeles,—the former an official department of the city, and the latter, a semi-official organization; each school having its own local club and these clubs coöperating with and aiding the schools in many ways. The Board of Education maintains that Out-Patient clinic known as the O. T. Johnson Public School Dispensary, and the Parent-Teacher Federation is the patron organization of the dispensary.

The dispensary occupies a three-story, concrete building fully equipped, and with the following departments: General medical, general surgical, skin diseases, eye, ear, nose and throat, speech defects, corrective physical training and orthopedic, nervous conditions, osteopathic, and dental. All the above are actively operating and are overcrowded. . . .

Narcotic Clinic Assured.—Los Angeles will establish a municipal dispensary and clinic for the decreasing dosage treatment of narcotic addicts. This was settled definitely at a meeting of the City Council after the councilmen listened to the amazing story of drug addiction, not alone in this city, but throughout the United States, as related by Collector of Internal Revenue John P. Carter, Health Commissioner L. M. Powers, Dr. John V. Barrow, Dr. Ross Moore, Dr. Dudley Fulton and others representing the County Medical Association. . . .

San Joaquin County.—The paper of the evening on *"Fracture of the Skull"* was presented by Dr. Howard Naffziger of San Francisco. Dr. Naffziger, who is in

(Continued on Page 40)

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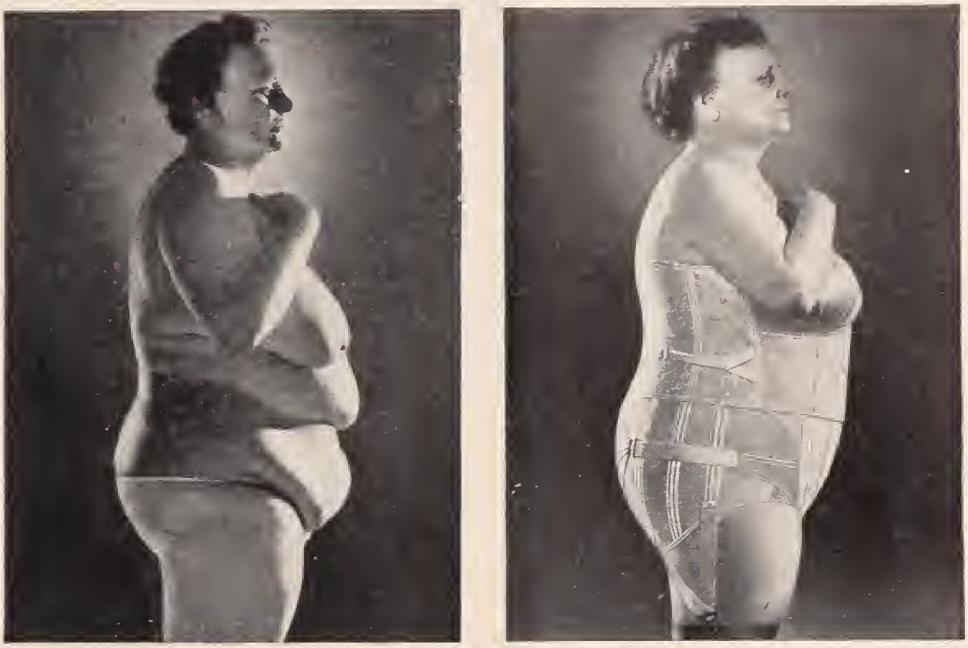

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*Guttmann, E. and Sargant, W.—B. M. J., 1:1013, 1937

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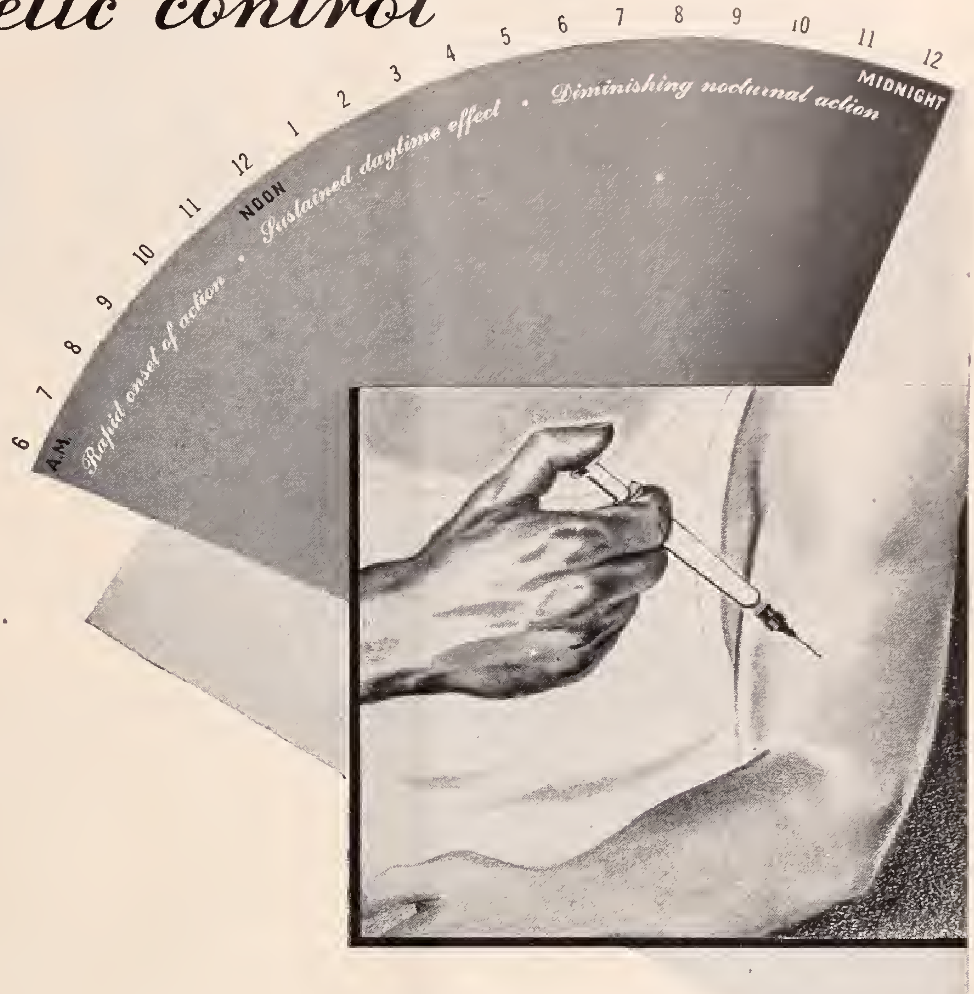
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TWENTY-FIVE YEARS AGO

(Continued from Page 30)

charge of the brain and nerve surgery of the University of California, and who but recently served as Lieutenant-Colonel in the Division of brain surgery with the American expeditionary forces in France, was able to speak with authority, based upon wide experience in his specialty. He spoke particularly of the type of case showing profound unconsciousness, slow pulse rate and other evidences of increased cranial pressure which can be relieved by a subtemporal decompression. The technique of this operation was illustrated by pictures thrown on the screen thereby making it more vivid and clear to his audience. After a short discussion, Dr. Naffziger answered various questions which were presented to him. The meeting adjourned at 11 p.m. . . .

From an Article on "Treatment of the Diphtheria Carrier, with Special Reference to Tonsillectomy and Adenoidectomy. With Report of 12 Cases," by Frank E. Detling, M.D., Los Angeles.—What to do with the diphtheria carrier is a problem, perplexing to doctors, health and hospital authorities, and most trying, inconvenient and expensive to patients.

The diphtheria carrier plays havoc with hospitals, especially institutions that limit their patients to children, frequently closing part or all of same, infecting and disorganizing the hospital forces, prolonged occupying of beds in the contagious departments, which are usually too limited even for ordinary requirements. The frequency of its unheralded appearance, and the general dis-

(Continued on Page 44)

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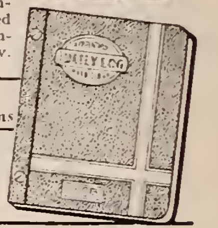

The DAILY LOG

TWENTY-FIVE YEARS AGO

(Continued from Page 40)

turbance it plays, make it customary to take throat cultures of all children as they enter children's wards, besides keeping them under observation for a limited time. In fact, I know of no other factor that plays such ruin with hospital efficiency. . . .

From an Article on "The Obstetrical Situation in France Today," by Titian Coffey, M.D., Los Angeles, Cal.—The obstetrical situation in France today is one that is causing grave concern to those most interested in the rehabilitation of this devastated country. Politicians,

(Continued on Page 46)

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TWENTY-FIVE YEARS AGO

(Continued from Page 44)

social workers, and medical profession, the church, all realize that something must be done on a grand scale to replace the depleted vigor of the nation, and to make up for the losses sustained in the past four years of this horrible war, to raise the fast-falling birth rate, to decrease the frightful infant mortality, to overcome tuberculosis and venereal disease, to put a stop to abortion, and to regulate prostitution. The problem is so vast, and involves so many complicated side issues, that one feels almost lost in attempting to grapple with it. Since the war of 1870 the birth rate of France has gradually decreased, so much so that, the average birth rate of civilized nations being 31.3 per cent, in 1913 the French birth rate was 18.8 per cent per 1,000 inhabitants, 40 per cent below the average, and this even before the nation entered the great war. . . .

BOARD OF MEDICAL EXAMINERS

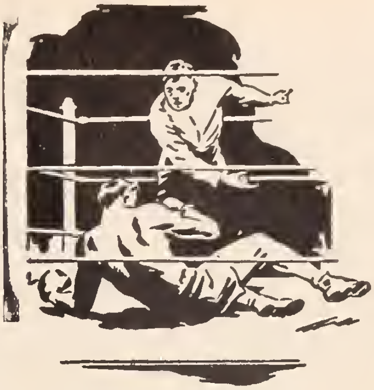
(Continued from Text Page 324)

court. Dr. Novotny was accused of possessing morphine in violation of the state code. His attorney, Russell H. Pray, contended that a physician and surgeon is permitted by law to buy drugs without a prescription. The acquitted man faces a similar charge in Long Beach superior court and was at liberty on bail at the time the Los Angeles case was filed. On the basis of yesterday's court ruling, Pray is expected to seek a dismissal of the local charge." (Long Beach *Independent*, Oct. 5, 1944.)

"Police Chief George Weight today said Max Otto Garten, 42, Salinas chiropractor, had been arrested on a charge of performing an illegal operation and was released on $2,000 bail. The complaint was signed by a Salinas woman." (Press dispatch dated Salinas, Sept. 15, published in S. F. *Examiner*, Sept. 16, 1944.)

"Dr. Grover C. Talbot, 54, San Jose chiropractor with offices at his home, 569 Atlanta Avenue, was placed in the county jail late yesterday for the second time in seven

(Continued on Page 47)



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BOARD OF MEDICAL EXAMINERS

(Contniued from Page 46)

years on charges of performing an illegal operation, this time on a 26-year-old San Jose divorcée, who was given even chances to recover by county hospital physicians. The divorcée whose identity is withheld, identified Talbot at the hospital, where he was taken by Joseph Williams, chief special agent for the state medical board. . . ." (San Jose *Mercury-Herald,* Oct. 25, 1944.)

"Petition for augmentation of the record in the appeal of Dr. Clyde A. Pierson, of San Bernardino, from a conviction on a charge of abortion, has been filed in the Fourth District Court of Appeal. The petition was filed by the appellant and seeks to bring up to the court all original instructions given the jury by Judge Charles L. Allison." (San Bernardino *Sun,* Oct. 4, 1944.)

"A statewide drive by the State Board of Pharmacy against a growing traffic in barbituric acid drugs was disclosed today in a report of Percy Heckendorf, director of the State Department of Professional and Vocational Standards, to Governor Warren. At the same time, Heckendorf disclosed, board investigators are attempting to determine the source of the sleep producing drug, a barbituric acid derivative, which was held responsible for the death of Aimee Semple McPherson, Los Angeles evangelist, in Oakland recently. Sale of the drug is restricted to a physician's prescription, which investigators said Mrs. McPherson apparently did not have. . . ." (San Francisco *Examiner,* October 26, 1944.)

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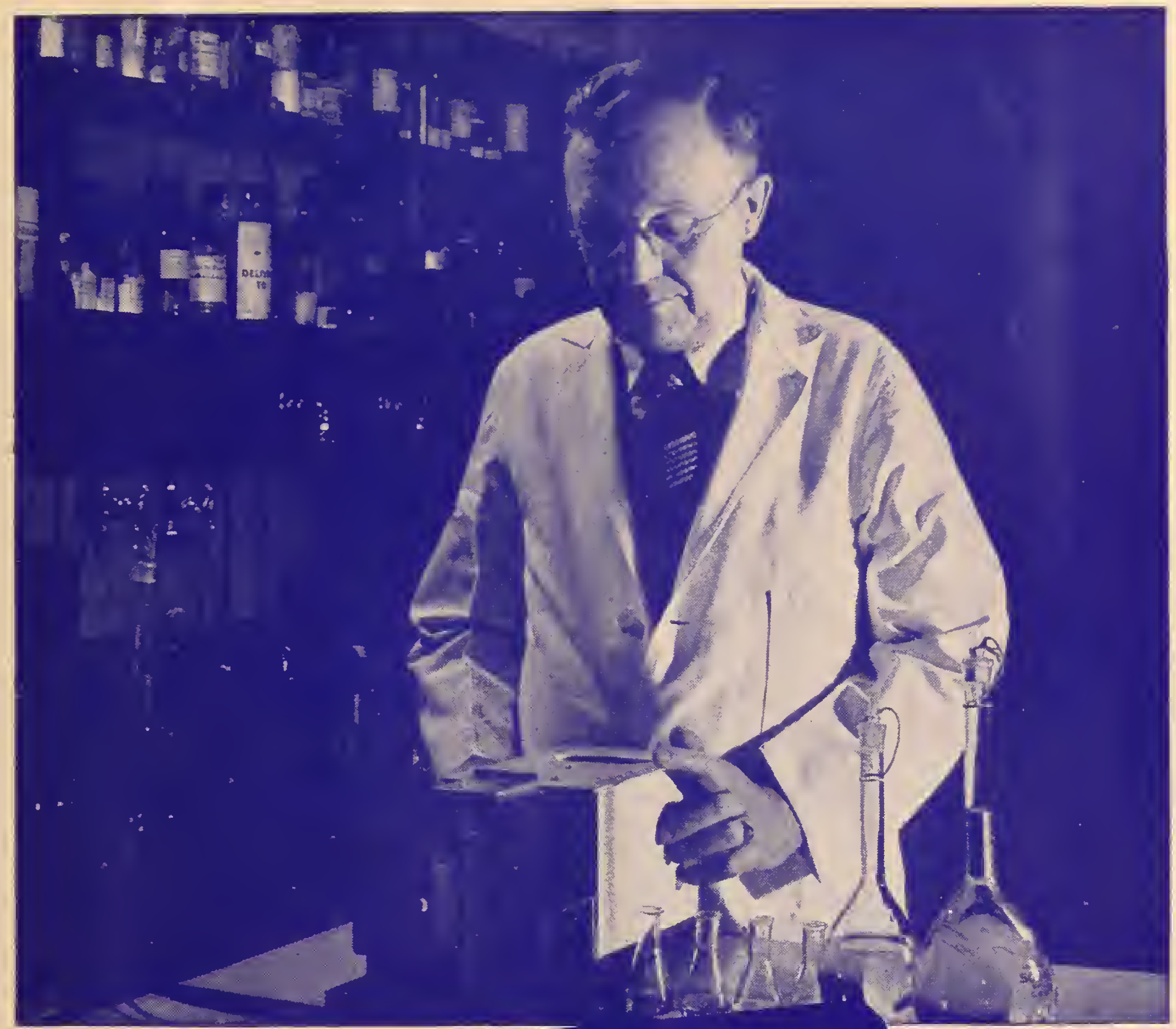

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